

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09488

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Effie				Alter	Month July 2, Day 1968 Year		11:00 p.m.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Female	white		February 16, 1881		87 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Kentucky		U.S.A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		Spring Grove State Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince George's		Beltsville				4902 Powder Mill Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
(dec.) John				Woods	Frazier, Melissa				(dec.)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address
						Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from May 17, 1967, to 7-2, 1968, that (we) saw the deceased alive on July 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		11669		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
								7-2-68	
22d. PHYSICIAN'S NAME (Type)		Raul L. Machado, M.D.		22e. ADDRESS		Spring Grove State Hospital Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/6/68		Mt. Gilead Cemetery		Slaughter Webster Kentucky			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons		Hyattsville, Maryland		JUL - 8 1968		Charles Judge			

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item # 1d Film 0402 7/15/68 km

09489

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>367 Stillwater Road 21221</u>				d. STREET ADDRESS <u>367 Stillwater Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>ALT</u> Last <u>VATER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1968</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 2-1899</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myocardial failure</u> DUE TO (c) <u>Arteriosclerotic Cardio-Vascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 wk</u> <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>68</u> , to <u>July 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 4</u> , 19 <u>68</u> , and that death occurred at <u>3P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>G.M. Boumgardner</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.M. Boumgardner</u>				22d. ADDRESS <u>Balto 21237</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/8/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		23d. LOCATION (City, town or county) (State) <u>Balto md.</u>	
24. FUNERAL DIRECTOR <u>J. S. Connolly Sons - Essex Md.</u>				25a. REC'D BY REGISTRAR <u>JUL - 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03100

ALVIER

LOUIS

03100



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 103  
8-16-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

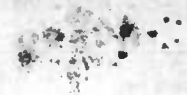
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08490

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
CHARLES FRANKLIN ANDERSON						7 12 1968			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	Jan. 16, 1942	26 YRS					July 12 1968			8:50 P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Balto. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Glyndon			Brewster Farm, Glyndon, MD			Clerk			Food Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Baltimore			Lutherville			30 Othoridge Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Fletcher R. Anderson Jr.			Gladys V. Price								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			218-40-4365			Fletcher R. Anderson Jr. 30 Othoridge Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>929.8</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. 7 ? 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Subject accidentally drowned</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Pool</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Tufts Ave. Balto. Md.</u>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Nature causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward F. Wilson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>July 12, 1968</u>			
EXAMINER'S NAME (Type) <u>Edward F. Wilson, M.D.</u>				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		7/16/68		Gardens of Faith Cemetery Baltimore, Maryland							
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson 1050 York Rd. 21204						DATE <u>JUL 18 1968</u>		<u>Charles Judge</u>			

00000

IN THE COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA



Jan. 1, 1942

U.S.A.

cc. 1000

1000



1000

1000

200-0-1000



1000

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>IVY</b>			First Middle Last <b>A ANDREWS, Jr.</b>			2a. DATE OF DEATH Month Day Year <b>JULY 14 1968</b>			2b. HOUR a. <b>6:10</b> M		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>MAY 5, 1910</b>			6. AGE (In years last birthday) <b>58</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMINISTRATION HOSP</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>DORCHESTER</b>			13c. CITY OR TOWN <b>CAMBRIDGE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>709 CHURCH STREET</b>			14. FATHER'S NAME First Middle Last <b>IVY A ANDREWS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>DAISY ROBBINS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW-11 214 07 9901</b>			17. INFORMANT Address <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>331x</b>											
19a. DATE OF OPERATION <b>July 11, 1968</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exploratory left Carotid Artery</b>			20a. AUTOPSY? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 9, 1968</b> , to <b>July 14, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 14, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>IRFAM AVNI ORER, M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>7 14 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>IRFAM AVNI ORER, M.D.</b>						22e. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>July 17, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>EPISCOPAL CHURCH CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>CAMBRIDGE DORCHESTER MARYLAND</b>		
24. FUNERAL DIRECTOR <b>Thomas Funeral Director, Locust St., Cambridge Md.</b>						25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Jaczi</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item#15e Film#G402 7/22/68										MARYLAND STATE DEPARTMENT OF HEALTH											
19484 Gibson Antonio										CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR	
HARRY Gibson ANTONIO										7 11 68										8:00 PM	
3. SEX M			4. RACE W			5. DATE OF BIRTH 8/11/1908			6. AGE (In years last birthday) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN						
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.												
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) STELLA MARIS HOSPICE				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 427 Marylander Apts. Dulaney Valley Rd. Balto., Md.											
14. FATHER'S NAME First Middle Last HARRY G. ANTONIO				15. MOTHER'S MAIDEN NAME First Middle Last DAISY WERNLE																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Hospice RECORDS Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction														acute							
2509 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Heart Disease														years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus severe														chronic							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
260 X																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from June 25, 1968, to July 4, 1968, that (I) (we) last saw the deceased alive on July 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>														22c. DATE SIGNED July 11, 1968							
22d. PHYSICIAN'S NAME (Type)														22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 7/15/68				23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.				23d. LOCATION (City or Town) (County) (State) Balto.									
24. FUNERAL DIRECTOR [Signature] ADDRESS [Signature] 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature]																					
DATE JUL 16 1968																					



1943

1943

1943



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Mildred		Middle Marie		Last APPLEGARTH		2a. DATE OF DEATH Month 7 Day 20 Year 68		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 26, 1927		6. AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				Md.	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY none					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY - / -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3416 Esther Place			
14. FATHER'S NAME First Middle Last Frank L. Applegarth		15. MOTHER'S MAIDEN NAME First Middle Last Lillie May Nelson BRIGGS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. no		17. INFORMANT Address McCORMICK							
				Rosewood Records, Owings Mills, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aortic insufficiency due to rheumatic fever</u> 3950 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Grand mal seizures, etiology not determined</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>since birth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 411X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>36</u> , to <u>7/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harry G. Butler M.D.</u>		22c. DATE SIGNED 7/22/68		22d. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.							
22e. ADDRESS Rosewood Lane, Owings Mills, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-25-68		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR <u>Philip E. Green 1211 Chasaco Ave.</u>		25a. REC'D BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

02370

20

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Albert			Alfred	Auchter	Jr.	7 Month 31 Day 68 Year			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Jan. 7, 1889		79 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Missouri		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Timonium			109 Charmuth Road			Accountant		Accounting	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Baltimore		Timonium			109 Charmuth Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Albert			Alfred	Auchter	Sr.	Lena Schmeltz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
yes			W.W. One		Mrs. Evelyn Havener, Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from April 17, 1968, to July 31, 1968, that (I) (we) last saw the deceased alive on June 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George T. Gilmore, M.D.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 31, 1968
22d. PHYSICIAN'S NAME (Type) George T. Gilmore, M. D.					22e. ADDRESS 1717 York Road - Lutherville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		Aug. 2, 1968		Dulaney Valley		Cockeysville, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204					25a. REC'D BY REGISTRAR DATE AUG 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

10/10/10

10/10/10

10/10/10





**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09487		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09495	
1. DECEASED-NAME (Type or print) First MIDDLE Last RAYMOND E. AUSTIN				2a. DATE OF DEATH Month Day Year JULY 9 1968			2b. HOUR 5:25PM
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 8/30/27		6. AGE (In years last birthday) 40 YRS.	
7a. BIRTHPLACE (State or foreign) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY, Md.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHAUFFEUR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1408 N. Mount Street		14. FATHER'S NAME First MIDDLE Last RUFUS AUSTIN		15. MOTHER'S MAIDEN NAME First MIDDLE Last FLORENCE REED			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16b. SOCIAL SECURITY NO. 216 20 89 56		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA RECENT 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 472X (b) PULMONARY EDEMA RECENT DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROSIS GENERALIZED							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/21/68, 19, to 7/9/68, 19, that (I) (we) last saw the deceased alive on 7/9/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				22c. DATE SIGNED 7/10/68		22d. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.	
22e. ADDRESS VAH FORT HOWARD, MARYLAND				22f. ADDRESS		22g. ADDRESS	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE 7-12-68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Vernon R. Boyle		ADDRESS KELSON FUNERAL HOME 1348 N. Calhoun St. Baltimore, Md.		25a. RECEIVED REGISTERED JUL 12 1968		REGISTERED SIGNATURE [Signature]	



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 211 film 405  
8-9-68 mt

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09482

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09496

1. DECEASED-NAME (Type or Print)		First ADON	Middle T.	Last AYOUB	20. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 7/22/'68		2b. HOUR M	
3. SEX M	4. RACE W	5. DATE OF BIRTH 3/29/'56		6. AGE (In years last birthday) 12 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 7/22/'68 Year 19	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		Md.
10. CITY OR TOWN OF DEATH Baltimore County		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 906 E. 36th Street
14. FATHER'S NAME Nicholas Ayoub		First	Middle	Last	15. MOTHER'S MAIDEN NAME Alyn Nadon		First	Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Nicholas Ayoub				ADDRESS 906 E. 36th Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7299								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. Edgemere		City or Town Balto. County Md		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Theo C. Patterson		EXAMINER'S NAME (Type) THEO C. PATTERSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7/23/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/25/'68		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR John A. Moran, Inc.				ADDRESS 3000 E. Baltimore St.		25a. REC'D BY REGISTRAR DATE JUL 25 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge		

00000

00000

2

1

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First <b>WILLIAM</b>			Middle <b>BACKUS</b>			Last <b>BACKUS</b>		
2a. DATE OF DEATH			Month <b>7</b>			Day <b>3</b>			Year <b>68</b>		
2b. HOUR <b>1:15 PM</b>											
3. SEX <b>MALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>2/23/25</b>			6. AGE (In years last birthday) <b>43</b>		
7a. BIRTHPLACE (State or foreign country) <b>Winston Salem, North Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CRANE OPERATOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>REFRACTORY</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e. STREET AND NUMBER <b>3325 Belle Avenue</b>											
14. FATHER'S NAME <b>ISREAL</b>			First <b>BACKUS</b>			15. MOTHER'S MAIDEN NAME <b>DIAGNE</b>			First <b>LOGAN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW 1 PL 28</b>			17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>OLD</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>442X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/25/68</b> , 19 <b>7/3/68</b> , 19 <b>7/3/68</b> , that (I) (we) last saw the deceased alive on <b>7/3/68</b> , 19 <b>7/3/68</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <b>(did not)</b> view the body after death.											
22b. SIGNATURE <b>Jorge A. Fabara</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>7/3/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>			22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>								
23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>			23b. DATE <b>7-8-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>MORTON &amp; DYETTE FUNERAL HOME</b>			ADDRESS <b>1701 LAURENS ST. BALTIMORE, MD.</b>			25a. RECD BY REGISTRAR <b>JUL - 8 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



1944

UNITED STATES OF AMERICA

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>CHARLES N. BAIR</b>						2a. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>2 4 M</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>1882 JULY 21, 1882</b>		6. AGE (In years last birthday) <b>86 85 YRS.</b>		IF UNDER 1 YEAR MONTHS <b>86</b> DAYS <b>85</b>		IF UNDER 24 HRS. HOURS <b>86</b> MIN <b>85</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>25 S. MORERICK AVE.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED STORE OWNER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>LIQUOR STORE OWNER</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>25 S. MORERICK AVE.</b>		
14. FATHER'S NAME First <b>ISAAC</b> Middle <b>BAIR</b> Last <b>BAIR</b>				15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>V.</b> Last <b>BARNES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216-44-5408</b>		17. INFORMANT Address <b>LEONARD W. BAIR, CATONSVILLE, MARYLAND</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CV Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR ±</b> <b>10 YRS ±</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4221</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>7/10</b> , 19 <b>68</b> , to <b>7/20</b> , 19 <b>68</b> , that (I) (we) saw the deceased alive on <b>7/10</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Phos E. G. Gough MD</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/20/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>THOS EITZOLD MD</b>						22e. ADDRESS <b>3350 BAZZELL NATL PK</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASHINGTON, MD.</b>					
24. FUNERAL DIRECTOR <b>Charles R. Rouse</b>						25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**ACKNOWLEDGMENTS**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item#13e FilmGL02 7/15/68km									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last Wilson Turner Ballard			2a. DATE OF DEATH 7 Month 8 Day 68 Year		2b. HOUR 2 PM	
3. SEX M		4. RACE W		5. DATE OF BIRTH 4-21-1893		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Lyons Mill Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Civil		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Lyons Mill Road	
14. FATHER'S NAME First Middle Last Dr. Edwin K. Ballard			15. MOTHER'S MAIDEN NAME First Middle Last Addie Virginia Chilcote						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WWI 214-16-6601		17. INFORMANT Address Mrs. Susan Catherine Ballard Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of rectum</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1965	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 154X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1968</u> , to <u>July 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Joseph D B King</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>July 9, 1968</u>		
22d. PHYSICIAN'S NAME (Type) Dr. Joseph D. B. King					22e. ADDRESS Cross Keys				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-10-68		23c. NAME OF CEMETERY OR CREMATORY St. Thomas'		23d. LOCATION (City or Town) (County) (State) Garrison Forest Md.			
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md.					25a. REC'D BY REGISTRAR DATE JUL 10 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

224

1990





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>LOUIS</b>			First Middle Lost			2a. DATE OF DEATH July Month 11 Day 1968			2b. HOUR 6:45pm
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>October 16, 1892</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>self-employed--Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3701 Bonview Av., 21213</b>	
14. FATHER'S NAME <b>Benedict Barbieri</b>			First Middle Lost			15. MOTHER'S MAIDEN NAME <b>Catherine Gentile</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Army WW 1</b>		16b. SOCIAL SECURITY NO. <b>217-32-7749</b>		17. INFORMANT <b>Dominic Barbieri, son, above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest secondary to</b> <b>5192</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Lung condition(?)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <b>5272</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>it</del> (this hospital) attended the deceased from <b>July 6</b> , 19 <b>68</b> , to <b>July 11</b> , 19 <b>68</b> , that <del>it</del> (we) last saw the deceased alive on <b>July 11</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lorna Gaudiol, M.D.</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7/11/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Lorna Gaudiol, M.D.</b>					22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Schmunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>					25a. REC'D BY REGISTRAR <b>JUL 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

00700

RECORDS OF DEATH

1910

JUL 1 1928

JUL 1 1928

JUL 1 1928

JUL 1 1928

JUL 1 1928

JUL 1 1928

JUL 1 1928

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <b>SADIE</b>			First Middle Last <b>SARAH BARTHOLOW</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>July 29 1968</b>		2b. HOUR <b>7:16</b> M.		
3. SEX <b>F</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH <b>6-14-1889</b>	6. AGE (In years last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>29</b> Year <b>1968</b>		2d. HOUR <b>7:16</b> M.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>		Md.		
10. CITY OR TOWN OF DEATH <b>LANS DOWNE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>117 Ridge Avenue</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdowne</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>117 Ridge Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Henry Williamson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ella Williamson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-12-0223</b>		17. INFORMANT ADDRESS <b>Mrs. Mildred Serio, 117 Ridge Avenue 21227</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5609</b> IMMEDIATE CAUSE (a) <b>Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 days</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5705</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>J. Nelson McKay</b>		EXAMINER'S NAME (Type) <b>J. NELSON MCKAY, MD</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>7/29/68</b>		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-31-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

1038

42

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

NOV 10 1930

NOV 10 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR a.m. p.m.	
John			J.	Baum	July 10, 1968			5:50 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
male		white		June 2, 1882		86 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U. S.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			newspaperman		Wash. Star		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Pr. Geo.		College Pk.		YES <input type="checkbox"/> NO <input type="checkbox"/>		9708 - 47th Place	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John			Baum			Hattie Omigoska				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		578-10-2394 Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>M.S.C.V.D.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <u>4221</u> <u>Acute pulmonary edema</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 24</u> , 19 <u>67</u> , to <u>JUL 10</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>JUL 10</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert Fisher</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/10/68</u>			
22d. PHYSICIAN'S NAME (Type) Robert Fisher, M.D.					22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7-13-1968		Rock Creek Cemetery		Washington, D.C.				
24. FUNERAL DIRECTOR ADDRESS Nalley Funeral Home Mt. Rainier, Md.					25a. REC'D BY REGISTRAR DATE <u>JUL 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00203

10 1953

John

White

June 1, 1953

10

John White, June 1, 1953

10 - 1953

10 - 1953

10 - 1953

10 - 1953

10 - 1953

10 - 1953

10

10 - 1953

10 - 1953

10 - 1953

10 - 1953

10 - 1953

10 - 1953

10 - 1953



## CERTIFICATE OF DEATH

09503

1. DECEASED-NAME (Type or print) <b>MARY</b>			First Middle Last <b>A BAUM</b>			2a. DATE OF DEATH Month Day Year <b>July 2 1968</b>			2b. HOUR <b>1:52p M</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>December 1, 1896</b>			6. AGE (In years last birthday) <b>71</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>BALTO</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>4101 Perry View Rd</b>			14. FATHER'S NAME First Middle Last <b>EDWARD FORREST</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>WRIGHT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-01-9426</b>			17. INFORMANT Address <b>James Galwell 4101 Perry View Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Myocardial Infarction - anteroseptal</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/2</b> , 19 <b>68</b> , to <b>7/2</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>7/2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Christina Feliciano</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>July 2, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Christina Feliciano</b>						22e. ADDRESS <b>7200 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/5/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Lassahn Funeral Home 7401 Belair Rd. 21236</b>						25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10288

222

*[Faint signature]*

820 01 101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
HENRY BEARD					July 9 1968			5:35 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		NEGRO		September 2, 1895		72 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Cockeysville				Box 82, Cuba Rd., Cockeysville	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
John Beard					Ella Mathews					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute Cardio Respiratory Insufficiency.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
4221										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (H) (this hospital) attended the deceased from <u>July 5</u> , 19 <u>68</u> , to <u>July 9</u> , 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>July 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
<u>Inez Cilliani</u>								7/10/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Inez Cilliani, M.D.					7620 York Rd. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7/12/68		Mt Auburn Cemetry		Baltimore Md				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Adolphus Halstead 1206 W North Ave					DATE JUL 12 1968		<u>Charles Judge</u>			

02304

02304

02304

02304

02304

02304

02304

02304

02304

02304

02304

02304

02304

02304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Alonzo			B.		Bell		Sr		Month 7 Day 20 Year 68		5:15 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male			White			10-14-1889			78 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			U.S.A.						Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			St. Joseph Hospital			Retired Conductor			Rail Road			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore			Parkville				3329 Madison Ave.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Henry			Bell						Mary		E Askew	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
No			A63-7938			Catherine Proell 7201 Shadow Lawn Ave 21234						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/18/68</u> , 19 <u>68</u> , to <u>7/20/</u> , 1968, that (I) (we) last saw the deceased alive on <u>7/20/</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			7-21-68			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			21204						
Inez Cilliani, M. D.			7620 York Road, Towson, Maryland,									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			7/24/68		Moreland Memorial Pk			Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Leonard J Ruck Inc Baltimore, Maryland						DATE 7/22/68		Charles Judge				

1960

00000



London

White

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09506

00493

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>WENDELL</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>7-26 1968</b>			2b. HOUR <b>6:00 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4-6-1920</b>		6. AGE (In years last birthday) <b>48 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Balto. Co.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Self employed</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Kingsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>21087 Belair Road Kingsville</b>			
14. FATHER'S NAME <b>William W.</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Bertha Standiort</b>			First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>#</b>		17. INFORMANT <b>Mrs Ruth C. Bell</b>			ADDRESS <b>21087 Belair Road Kingsville Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9026</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>6:10 P.M. 7-25 1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell off bar stool</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>tavern</b>			21f. LOCATION Street or R.F.D. No. <b>Kingsville</b>			City or Town <b>Baltimore</b>		County State <b>Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) 22b. DATE SIGNED <b>July 27, 1968</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7-29-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Methodist Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>					
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road 21236</b>						25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

000



RECEIVED

NOV 1950

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 402 Maryland State Department of Health  
7-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09499

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09507

1. DECEASED-NAME (Type or Print) <b>ELIZABETH C BENDER</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>1968</b>			2b. HOUR <b>2:00</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Dec. 1, 1915</b>	6. AGE (In years last birthday) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>8</b> , Year <b>1968</b>
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>
10. CITY OR TOWN OF DEATH <b>Carney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9919 Harford Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>9919 Harford Road</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>Charles</b> Middle <b>F</b> Last <b>Richards</b>			15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>E</b> Last <b>Switzer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-01-0778</b>		17. INFORMANT <b>Mr Grover C Bender</b>		ADDRESS <b>Same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Overdose of barbiturate</b> <b>9500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>9702</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR <b>2:00</b> P.M. <b>July 8 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Overdose of barbiturate</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>9919 Harford Rd.</b>		City or Town <b>-</b>	County <b>Baltimore</b> State <b>Md.</b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>		EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>July 8, 1968</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>7/11/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. RECEIVED BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>

05507

RECORDS OF DEATH

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician ~~and~~ completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and an entry made within 72 hours after death.

0308

001: 00



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>MARTIN K. BISTRESKI</b>			2a. DATE OF DEATH Month Day Year <b>JULY 24 1968</b>			2b. HOUR 1:35 PM			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAR 15, 1892</b>		6. AGE (In years last birthday) <b>76 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUMMIT NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLOTHING DRESSER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>755 Ramsey St.</b>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-03-7169</b>		17. INFORMANT Address <b>Charles H. Bistrick 432 Shipley Rd. 21040</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF BRAIN</b> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CANCER OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos +</b> <b>4 mos +</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163 X ARTERIOSCLEROSIS</b>									
19a. DATE OF OPERATION <b>6/10/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TUMOR OF BRAIN</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1968</b> to <b>July 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 23, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John N. Snyder, MD</b>		22c. DATE SIGNED <b>7/24/68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN N. SNYDER MD</b>					
22e. ADDRESS <b>6348 FREDERICK RD CATONSVILLE MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Houder PARK Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>AMBROSE Inc. 1328 Sulphur Spring Rd.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

00380

00380

00380

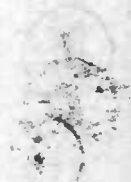
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
.CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
JOHN R BLANK						July Month 19 Day 1968			8:40 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		8/9/1880		87 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md. U.S.		U.S.				Balt. Co. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville, Md.			Summit Nursing Home			Back-keeper			Sales		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Balt.		Balt				6043 Gwynn Oak Ave.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Unknown						Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			No			Nsg Home Needs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Congestive heart failure due to											
4129 DUE TO, OR AS A CONSEQUENCE OF The patient's chronic											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) vascular disease.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1/30, 1968, to 7/19, 1968, that (I) (we) last saw the deceased alive on 7/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. KASAITIS M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/19/68			
22d. PHYSICIAN'S NAME (Type) E. KASAITIS, M.D.						22e. ADDRESS 1801 FREDERICK RD BALTO *28					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			7-22-68		New Cathedral Cem			Baltimore Md			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Thomas J. Kenny Inc						1600 Hollins St		JUL 22 1968		J. Charles Judge	

01380

2773



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>09503</div> <div>CERTIFICATE OF DEATH</div> <div>09511</div>										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last Irene A. Blue					7 Month 19 Day 68 Year			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
F		Cauc.		Sept. 6, 1923		44 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Walensburg, Col.			U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			1206 Ridervale Rd.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Baltimore		Towson					
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Harry Welch					Amelia Baca					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			523 22 0867		Rupert A. Blue 1206 Ridervale Rd. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Breast</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Phys.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
170X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 19 66, to July 19 68, that (I) (we) saw the deceased alive on July 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Charles F. O'Donnell</u>					22c. DATE SIGNED <u>7/22/68</u>		22d. PHYSICIAN'S NAME (Type)			
Charles F. O'Donnell					22e. ADDRESS 7501 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 23, 68		Dulaney Valley		Cockeysville, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson, Towson, Md.					DATE JUL 25 1968		<u>Charles Judge</u>			

11280

11280





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>09504</span> <span>CERTIFICATE OF DEATH</span> <span>09512</span> </div>									
Item #10, Film GL403 7/31/68 km									
1. DECEASED-NAME (Type or print) First Middle Last <b>DAVID BLUM</b>						2a. DATE OF DEATH Month Day Year <b>JULY 17, 1968</b>		2b. HOUR <b>PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3512 JO ANN DRIVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PROPRIETOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL STORE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3512 JO ANN DRIVE #21207</b>	
14. FATHER'S NAME First Middle Last <b>ISAAC BLUM</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>REBECCA ?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-12-4837</b>		17. INFORMANT Address <b>MRS. MINDELLE WEXLER, 3417 MILFORD MILL ROAD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema</b> <b>492 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>571 Conway Arley Avenue</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph B. Gross</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>July 17 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOSEPH B. GROSS</b>		22e. ADDRESS <b>6911 PARK HEIGHTS AVENUE</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI JACOB</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

08512

08512

JULY 17, 1952

BLIND

PAVIL

71

JUNE 1951

WHITE

MALE

BALTIMORE

X

U.S.A.

RUSSIA

RETAIL STORE

PROPRIETOR

3212 30 VAN DRIVE

21207

X 2512 10 VAN DRIVE

BALTIMORE

MARYLAND

?

REDECO

BLIND

ISAAC

212-12-1237 MRS. MINNELL BEXLEY, 2117 WILSON WIL ROAD

NO

4011 INK HOLLOW AVENUE

JOSEPH E. CROSS

BALTIMORE, MARYLAND

DAVID JACOB

7-12-51

201 CANTON & 2002, 610 WASHINGTON ST

JUL 2 1952

1  
09503  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH  
09513  
24 HOUR  
A M  
1  
FEMALE  
CAU  
1887  
9-05-1987  
30  
YRS.  
MONTHS  
DAYS  
HOURS  
MIN  
7  
Month 25 Day 68 Year  
1. DECEASED-NAME (Type or print) First Middle Last INEZ JANIE BOARTFIELD  
2a. DATE OF DEATH  
7. AGE (In years last birthday) 30  
IF UNDER 1 YEAR MONTHS DAYS  
IF UNDER 24 HRS. HOURS MIN  
3. SEX  
4. RACE  
5. DATE OF BIRTH  
6. AGE (In years last birthday)  
7. BIRTHPLACE (State or foreign country) GEORGIA  
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
9. COUNTY OF DEATH BALTIMORE Md.  
10. CITY OR TOWN OF DEATH Towson  
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTIMORE MED CENTER  
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife  
12b. KIND OF BUSINESS OR INDUSTRY  
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN YES ☒ NO ☐ 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER 415 E. BIDDLE ST.  
14. FATHER'S NAME First Middle Last ROBERT MANN  
15. MOTHER'S MAIDEN NAME First Middle Last ESTELLE Duncan  
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) 16b. SOCIAL SECURITY NO. 216-07-6084 17. INFORMANT PATIENT'S CHART Address  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 1560 HEPATIC COMA  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LIVER METASTASIS  
DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE GALLBLADDER  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1551  
19a. DATE OF OPERATION 7-13-68 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAPAROTOMY 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  
21d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 21f. LOCATION Street or R.F.D. No. City or Town County State  
22a. I certify that (I) (this hospital) attended the deceased from 7-6-68, 19\_\_\_\_, to 7-25-68, 19\_\_\_\_, that (I) (we) last saw the deceased alive on 7-25-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  
22b. SIGNATURE ER Soudijn DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22c. DATE SIGNED 7-25-68  
22d. PHYSICIAN'S NAME (Type) EDUARD R. SOUDIJN 22e. ADDRESS GREATER BALTO. MEDICAL CENTER  
23a. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE 7/27/68 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial 23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md.  
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St. 25a. REC'D BY REGISTRAR DATE JUL 29 1968 25b. REGISTRAR'S SIGNATURE J Charles Judge

MEDICAL CERTIFICATION  
2

81300

RECEIVED IN DEPT

43723

CHIEF OF BUREAU

DEPT

OFFICE OF THE

SEC

SECRET

RECEIVED

DEPT

SECRET

OFFICE OF THE

RECEIVED IN DEPT

DEPT

RECEIVED

DEPT

RECEIVED IN DEPT

CHIEF OF BUREAU

DEPT

RECEIVED IN DEPT

RECEIVED IN DEPT

DEPT

RECEIVED

DEPT

SECRET

RECEIVED

DEPT

RECEIVED IN DEPT

RECEIVED IN DEPT

DEPT

SECRET

SECRET

RECEIVED

RECEIVED IN DEPT

DEPT

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the certificate should be removed from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: STOCKERT FUNERAL HOME, FLAT WOODS, WEST VIRGINIA

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>HENCH</b> <b>WOODROW</b> <b>BOSLEY</b>					2a. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>68</b>		2b. HOUR <b>10:00AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9/3/16</b>		6. AGE (In years last birthday) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md.				
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CARPENTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>DUNDALK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3807 Old North Point Road</b>		
14. FATHER'S NAME <b>SCOTT</b>			15. MOTHER'S MAIDEN NAME <b>ALLIE</b>		16. SOCIAL SECURITY NO. <b>234 14 04 25</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> <b>5718</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>TOXIC HEPATITIS AND FATTY CIRRHOSIS OF LIVER</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RECENT &amp; OLD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>5810</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>7/16/68</b> , 19 <b>68</b> , to <b>7/26/68</b> , 19 <b>68</b> , that (h) (we) last saw the deceased alive on <b>7/26/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>George C. McElpatrick, M.D.</b>					22c. DATE SIGNED <b>7/26/68</b>		22d. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M.D.</b>			
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>		23b. DATE <b>7/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shock Cemetery</b>		23d. LOCATION (City or Town) <b>FLAT WOODS, WEST VIRGINIA</b> (County) <b>Flower</b> (State)				
24. FUNERAL DIRECTOR <b>ZANNINO FUNERAL HOME</b> <b>257 S. Conkling St. Baltimore, Md.</b>					25a. REC'D BY REGISTRAR <b>AUG 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

08214

08214



UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. Some words like "BUREAU", "NEW YORK", and "RE: [illegible]" are partially visible.]



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09507

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09515

1. DECEASED-NAME (Type or Print) <b>Roy Millard Basley</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>July 15 1968</b>			2b. HOUR <b>2:27 P.M.</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Mar. 20, 1911</b>	6. AGE (In years last birthday) <b>57</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>15</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Horse Owner/Trainer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Phoenix</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Paper Mill Road</b>
14. FATHER'S NAME First <b>William H.</b> Middle <b>Basley</b> Last <b>Kola Mae Wilson</b>			15. MOTHER'S MAIDEN NAME First <b>Kola Mae</b> Middle <b>Wilson</b> Last <b>Wilson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-18-0918</b>		17. INFORMANT <b>Family Records</b>		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>Sudden</b> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary Artery Disease</b> (b) <b>2 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>7/15/68</b>		
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>July 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dukiner Valley Memorial</b>		23d. LOCATION (City or Town) <b>Chickensville, Md.</b>		(County) (State)
24. FUNERAL DIRECTOR <b>John Busan's Sons, Towson, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

12582

08515

12582

12582

12582

12582

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09508

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09516

1. DECEASED-NAME (Type or Print) <b>LEROY BRIGHTWELL</b>						2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> <b>JULY 18 1968</b>			2b. HOUR M				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11/28/90</b>		6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO</b>			Md.		
10. CITY OR TOWN OF DEATH <b>ESSEX</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>210 KINGSTON PK.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY <b>CAN</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MO</b>				13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>210 KINGSTON PK</b>			
14. FATHER'S NAME First Middle Last <b>WILLIAM BRIGHTWELL</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>P</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>215-01-6538</b>		17. INFORMANT <b>ROSE BRIGHTWELL</b>				ADDRESS <b>ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 HCN</b>													
19a. DATE OF OPERATION <b>7/22/68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>HCN</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Charles J. Connelly</b>				EXAMINER'S NAME (Type) <b>J H C PATTERSON</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>7/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>		22b. DATE SIGNED <b>7/24/68</b>			
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>						ADDRESS <b>300 MALE</b>		25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Connelly</b>			

03518

RECEIVED

03518

RECEIVED



RECEIVED

(NOT)

X

RECEIVED

RECEIVED

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09509										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09517									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or Print) <b>CHARLES</b>					First <b>G.</b>					Middle <b>BROWN</b>					Lost <b>SR.</b>					2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <b>9</b> , 19 <b>68</b>					2b. HOUR <b>10:15</b>				
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>4/5/18</b>			6. AGE (In years last birthday) <b>50</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>			2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>9</b> , Year <b>1968</b>					2d. HOUR <b>10:15</b>						
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>					7b. CITIZEN OF WHAT COUNTRY? <b>Md. U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Baltimore</b>														
10. CITY OR TOWN OF DEATH <b>Ft. Howard</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fort Howard Va. Hospital</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Attendant- Hess Service Station</b>					12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>										13b. COUNTY <b>Baltimore</b>					13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>4327 Brehms Lane</b>				
14. FATHER'S NAME <b>George</b>					First <b>George</b>					Middle <b>Brown</b>					Lost <b></b>					15. MOTHER'S MAIDEN NAME <b>Emma Lorenz</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes-Army</b>										16b. SOCIAL SECURITY NO. <b>WW 1 215-07-1570</b>					17. INFORMANT <b>Esther Berends Brown, wife, above</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshotwound of Spine complicated by Bronchopneumonia</b> <b>969X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>and Paralysis</b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>964X</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year <b>2:30 xx Nov. 11, 65</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shot during holdup</b>																			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Gas Station</b>					21f. LOCATION Street or R.F.D. No. City or Town County State <b>3100 Pulaski Highway Baltimore M.D.</b>																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)										22b. DATE SIGNED <b>July 10, 1968</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>7/12/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>					23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>														
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>										ADDRESS <b>3331 Brehms Lane</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 12 1968</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



0017

0000

FOR STATE  
RECORDS  
DIVISION



EXHIBIT

EXHIBIT

EXHIBIT

EXHIBIT 1 - 10-10-10

EXHIBIT 2 - 10-10-10

EXHIBIT 3 - 10-10-10

EXHIBIT 4 - 10-10-10

EXHIBIT 5 - 10-10-10

EXHIBIT 6 - 10-10-10

EXHIBIT 7 - 10-10-10

EXHIBIT 8 - 10-10-10

EXHIBIT 9 - 10-10-10

EXHIBIT 10 - 10-10-10

EXHIBIT 11 - 10-10-10

EXHIBIT 12 - 10-10-10

EXHIBIT 13 - 10-10-10

EXHIBIT 14 - 10-10-10

EXHIBIT 15 - 10-10-10

EXHIBIT 16 - 10-10-10

EXHIBIT 17 - 10-10-10

EXHIBIT 18 - 10-10-10

EXHIBIT 19 - 10-10-10

EXHIBIT 20 - 10-10-10

EXHIBIT 21 - 10-10-10

EXHIBIT 22 - 10-10-10

EXHIBIT 23 - 10-10-10

EXHIBIT 24 - 10-10-10

EXHIBIT 25 - 10-10-10

EXHIBIT 26 - 10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 M  
30M REV. 11-66

09510		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		09519	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <b>KENT</b>			2a. DATE OF DEATH Month <b>7</b> Day <b>6</b> Year <b>68</b>		2b. HOUR <b>3:50</b> M
3. SEX <b>M</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>4.17.1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Unknown</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Mt. Wilson</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <b>Md.</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>McVictoria</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME <b>Unknown</b>		15. MOTHER'S MAIDEN NAME <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>212-38-3697</b>		17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic heart disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200 Pulmonary Tuberculosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7.1.1968</b> , to <b>7.6.1968</b> , that (I) (we) last saw the deceased alive on <b>7.6.1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William Newcomer</b>				22c. DATE SIGNED <b>7.6.1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 9, 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Meth</b>		23d. LOCATION (City or Town) (County) (State) <b>Shiloh, Charles, Md.</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1940

EXHIBIT A

1940

1940

1940

1940



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09511

09520

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First MELVIN			Middle W.			Last BROWN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7/9 68			2b. HOUR 12 noon					
3. SEX male		4. RACE negro		5. DATE OF BIRTH 12/3/33		6. AGE (In years last birthday) 34 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year July 9, 1968			2d. HOUR noon					
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore				Md.				
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 305 Melancton Ave.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) porter				12b. KIND OF BUSINESS OR INDUSTRY freelance								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Towson				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 619 Seminary Avenue						
14. FATHER'S NAME			First Arthur			Middle Brown			Last Rosalie			15. MOTHER'S MAIDEN NAME			First Lillian			Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Korean				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Korean 213-86-5506				17. INFORMANT Theresa Brown-617 W. Seminary Ave				ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7294																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 11 AM 7/9/ 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. drowned												
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) private swimming pool				21f. LOCATION Street or R.F.D. No. City or Town County State Baltimore, Md.												
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 7/9/68								
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 7/15/68				23c. NAME OF CEMETERY OR CREMATORY Balt. Nat.				23d. LOCATION (City or Town) (County) (State) Balt. Md.								
24. FUNERAL DIRECTOR Wm. L. Chaturan Jr. - 1701 McCulloch St								ADDRESS				25a. REC'D BY REGISTRAR JUL 12 1968				25b. REGISTRAR'S SIGNATURE Charles Judge				

08220

RECEIVED JUL 1 1968

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Carl E. Brust Sr.</b>						2a. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>1:45AM</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>August 31, 1894</b>			6. AGE (In years lost birthday) <b>73</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired-U.S. Post Office</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>5640-A Woodmont Ave.</b>			14. FATHER'S NAME First <b>Ernst</b> Middle <b>Brust</b> Last <b>Brust</b>			15. MOTHER'S MAIDEN NAME First <b>Emily</b> Middle <b>Frederick</b> Last <b>Frederick</b>			17. INFORMANT <b>Mrs. Catherine A. Brust</b> Address <b>5640A Woodmont Ave</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b> (If yes give year or dates of service) <b>WWI</b>			16b. SOCIAL SECURITY NO. <b>217-34-4607</b>			17. INFORMANT <b>Mrs. Catherine A. Brust</b> Address <b>5640A Woodmont Ave</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>Massive</b> IMMEDIATE CAUSE (a) <b>Small bowel infarction secondary to mesenteric artery thrombosis.</b> 4442 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>5702</b>											
19a. DATE OF OPERATION <b>7-27-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated viscus</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work <input type="checkbox"/> at home <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 26, 1968</b> , to <b>July 28, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Christine Feliciano, M.D.</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>July 28, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Christine Feliciano, M.D.</b>						22e. ADDRESS <b>7620 York Rd. Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/31/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Baltimore St.</b>						25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

15245

6



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
09513					09522					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last <b>Bessie Buhman</b>					Month Day Year <b>7 24 68</b>			2 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
<b>F</b>		<b>W</b>		<b>12/7/1881</b>			<b>86 YRS.</b>			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
<b>Balto., Md.</b>		<b>U.S.A.</b>				<b>Baltimore Md.</b>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
<b>Cockeysville</b>		<b>417 Wake Robin Drive</b>			<b>Homemaker</b>			<b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
<b>Md.</b>		<b>Baltimore</b>		<b>Cockeysville</b>				<b>417 Wake Robin Drive</b>		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
<b>Robert Scott</b>			<b>Jane (Unknown)</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
<b>No</b>			<b>215-48-7212</b>		<b>Jl Mrs. William Johannis (Same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 13 hours DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> 2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>January, 1968</b> , to <b>July 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>5/10/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
<b>George T. Gilmore</b>		<b>July 24, 1968</b>		<b>George T. Gilmore, M. D.</b>						
22e. ADDRESS		22f. ADDRESS								
<b>Lutherville, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<b>Burial</b>		<b>7/27/68</b>		<b>Western</b>		<b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
<b>H.W. Jenkins &amp; Sons Co.</b>		<b>4905 York Road</b>		<b>Jul 25 1968</b>		<b>Charles Judge</b>				
<b>Balto., Md.</b>										

RECEIVED

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Elizabeth</b>						2a. DATE OF DEATH <b>July</b> Month <b>19</b> Day <b>1968</b>		2b. HOUR <b>12:15</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-1-1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Lutherville</b>		13c. CITY OR TOWN <b>LUTHERVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1017 W. Seminary Avenue</b>			
14. FATHER'S NAME First Middle Last <b>Williamson J. Carter</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Carrie Dufur</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>216-46-2989</b>		17. INFORMANT Address <b>Mrs. Paul Ford, 103 Hopkins Rd.-12</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary embolism</b> <b>450X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>465X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (a) (this hospital) attended the deceased from <b>7-11</b> , 19 <b>68</b> , to <b>7-19</b> , 19 <b>68</b> , that (x) (we) last saw the deceased alive on <b>7-19</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Christine Feliciano, M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7-19-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Christine Feliciano, M.D.</b>						22e. ADDRESS <b>7620 York Road, Towson, Maryland 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto.</b>					
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, 6500 York Rd. 21212</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 22 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ramona Beach</b>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>3121 E. Monument Street</b>					
3. NAME OF DECEASED (Type or print) <b>MICKEY RAY BURNETTE</b>						4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1968</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>American Indian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1946</b>		9. AGE (In years last birthday) <b>22 yrs.</b>		IF UNDER 1 YEAR Months <b>22</b> Days <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lumberton, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Burnette</b>						14. MOTHER'S MAIDEN NAME <b>Delois Revels</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Varser Burnette 3121 E. Monument Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decedent Drowning</b> 910.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prob intoxication</b> 9294 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>see above</b>											
20c. TIME OF INJURY Hour a.m. <b>—</b> p.m. <b>—</b> 19 <b>68</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Miller's Island Edgemere</b>		20f. (City or town) <b>Balto</b>		(County) <b>Md</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Theo C Patterson</b> M.D. EXAMINER'S NAME (Type) <b>THEO. C PATTERSON</b> Address (Street, city, town, or county) <b>7/23/68</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-24-1968</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ten Mile Center</b>		22d. LOCATION (City, town, or country) (State) <b>Lumberton, North Carolian</b>					
23. FUNERAL DIRECTOR ADDRESS <b>1901-07 Eastern Avenue Lilly &amp; Zeiler Inc.</b>						24a. REC'D BY REGISTRAR DATE <b>JUL 26 1968</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <b>JAMES</b>			First Middle Last <b>BURNS</b>			2a. DATE KNOWN OF DEATH Month Day Year <input type="checkbox"/> <b>July 8, 1968</b>		2b. HOUR :50 M	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>5-12-51</b>	6. AGE (In years last birthday) <b>17</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <b>July 8, 1968</b>		2d. HOUR 7:50 M	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Busboy</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>153 N. Curley Street</b>	
14. FATHER'S NAME First Middle Last <b>Norman Burns</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Juanita Bailey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Juanita Burns 153 N. Curley St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> <b>965X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>981X</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>1:15 PM July 8, 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shot during holdup</b>				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Shopping Center</b>		21f. LOCATION Street or R.F.D. No. <b>York Road Plaza</b>		City or Town <b>Baltimore M.D.</b>		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>			EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>July 8, 1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>Bernard Dabrowski 2818 E. Baltimore St.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

33525

33525



33525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09517		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09526	
Item#10,11,FilmG402 7/15/68km		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last MARIAN E BUTTS			2a. DATE OF DEATH Month Day Year JULY 6 1968			2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 21, 1914		6. AGE (In years last birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? —		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTO. CO. Md.	
10. CITY OR TOWN OF DEATH Essex Balto. Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PRESSER		12b. KIND OF BUSINESS OR INDUSTRY DRY CLEAN. RM	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 822 BRUNSWICK RD. 21		14. FATHER'S NAME First Middle Last HENRY E ZENTGRAF		15. MOTHER'S MAIDEN NAME First Middle Last META H ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) —		16b. SOCIAL SECURITY NO. —		17. INFORMANT CECELIA ACROCKEN		Address SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AS HTD. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb, 1965, to July, 1968, that (I) (we) last saw the deceased alive on July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. J. LYDIE, M.D.				DEGREE ATTENDING PHYS.		22c. DATE SIGNED 7/8/68	
22d. PHYSICIAN'S NAME (Type) R. J. LYDIE, M.D.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/9/68		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR Connolly Sons				ADDRESS 300 MACE AVE. 21		25a. REC'D BY REGISTRAR JUL 10 1968	
						25b. REGISTRAR'S SIGNATURE J. Charles Judge	

02034

RECEIVED

1171

3

RECEIVED  
100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09518				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09527			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
First Middle Last <b>WILLIAM --- CAMPER</b>				Month Day Year <b>July 7 1968</b>				A <b>6:15 M</b>			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>6/26/95</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Fort Howard</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hospital Veterans Administration</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland - Balto</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1935 Harlem Avenue</b>			
14. FATHER'S NAME First Middle Last <b>ANDREW - - CAMPER</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Camper</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes WW-1</b>				16b. SOCIAL SECURITY NO. <b>213 10 24 65</b>		17. INFORMANT Address <b>Clinical Reds VA Hospital, Fort Howard, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY ABCESS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF PROSTATE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>			
								<b>WEEKS</b>			
								<b>YEARS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>177X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>June 26, 1968, to July 7, 1968</b>							
22a. I certify that (X) (this hospital) attended the deceased from <b>June 26, 1968</b> , to <b>July 7, 1968</b> , that (X) (we) last saw the deceased alive on <b>July 7, 1968</b> and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.								22b. SIGNATURE <b>Mario J. Quiros, M.D.</b> DEGREE 22c. DATE SIGNED <b>7/7/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>MARIO J. QUIROS, M.D.</b>		22e. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>Charles A. Rice</b>		24a. ADDRESS <b>661 W. Barre St. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>					

100

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Thomas Edward CARDINALE</b>					2a. DATE OF DEATH Month Day Year <b>July 25, 1968</b>			2b. HOUR <b>9:50 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 23, 1968</b>		6. AGE (In years last birthday) YRS. MONTHS DAYS <b>1 1 1</b>		IF UNDER 1 YEAR MONTHS DAYS <b>1 1</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7741 Charlesmont Rd.</b>			
14. FATHER'S NAME First Middle Last <b>Thomas Anthony Cardinale</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Frances Tanks</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Thomas A. Cardinale (Same)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>7762</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory distress syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>7735</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <b>7/23/</b> , 19 <b>68</b> , to <b>7/25/</b> , 19 <b>68</b> , that (we) last saw the deceased alive on <b>7/25/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Imelda Salanio, M.D.</b> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>July 25, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Imelda Salanio, M.D.</b>					22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/27/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery,</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

1111

1111

DEPARTMENT OF HEALTH

July 2, 1968

Watts

Watts

Baltimore

U.S.

U.S.

Watts

U.S. District Court

U.S.

U.S. District Court

Baltimore

U.S. District Court

U.S. District Court

U.S. District Court

U.S. District Court

U.S. District Court

U.S. District Court

U.S. District Court

U.S. District Court

U.S. District Court

Watts

July 2, 1968

Watts

Watts

July 2, 1968

U.S. District Court

U.S. District Court

U.S. District Court

Watts

U.S. District Court

U.S. District Court

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09520										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09529									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First			Middle			Last				Month			Day			Year			HOURS			MIN.							
James			T.			Carey				July			10			1968			9:40a			M							
3. SEX			4. RACE			5. DATE OF BIRTH				6. AGE (In years last birthday)			7. UNDER 1 YEAR			8. UNDER 24 HRS.													
Male			White			11-10-1895				72			YRS.			MONTHS			DAYS			HOURS			MIN.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH										Md.									
Kentucky			U.S.A.							Baltimore																			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY																			
Towson			St. Joseph's Hosp.			Retired - Baker Schmidt's																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																
Maryland			City			Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5610 Woodmont Ave., 21212																
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First			Middle			Last								
Jessie			Carey						Bertha			Vail																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				Address																			
No			216-10-9639A			Mrs. Carolyn M. Carey				(Same)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>																													
4109																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b) <u>Congestive Heart Failure</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) <u>Coronary Arteriosclerosis with thrombosis of right coronary artery</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										artery																			
4201																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			HOUR A.M. Month Day Year P.M. 19																										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION																							
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State																							
22a. I certify that (M) (this hospital) attended the deceased from 7-10, 19 68, to 7-10 19 68, that (H) (we) lost the deceased alive on 7-10 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)							22e. ADDRESS																
I Cilliani			7-10-68			Inez Cilliani, M.D.							6720 York Rd. 21204																
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
Inez Cilliani, M.D.			6720 York Rd. 21204																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																			
Burial			7/12/1968			Lorraine Park				Woodlawn Balto. Co., Md.																			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																							
H.W. Jenkins & Sons Co.			4905 York Rd. Balto. 12, Md.			JUL 11 1968				Charles Judge																			

11-15-1958

00220

RECEIVED DEPT. OF STATE

00000

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

11-15-1958

1  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Alfred Charles			CARON, III			7 Month 29 Day 68 Year			1:30 <sup>am</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		4/30/67		1		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Greater Balto. Med. Center			None		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Baltimore		Balto. 21234		YES <input type="checkbox"/> NO <input type="checkbox"/>		1348 Dartmouth Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Alfred Charles Caron, Jr.			Noel A. Tischringer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
					A.C. Caron, Jr. Same as # 13 A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus and meningomyelocele</u>										
7410 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
751.2										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> , 19 <u>67</u> , to <u>7/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>DOA</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<i>R. Breiteneker</i>								7/29/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
R. Breiteneker, M.D.				6701 N. Charles Street						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 31, 1968		Dulaney Valley		Cockeysville, Md				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson, 1050 York Rd. Towson, Md. 21204						AUG 1 1968		<i>J. Charles Judge</i>		

00320

RECEIVED

00320

7. 19 2012

1. 19 2012

*Handwritten signature*

*Handwritten text*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
George			Henry			Carr			7 10 68 6:25 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		white		March 11, 1877			91 YRS.		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Baltimore County Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		Spring Grove State Hospital			Unemployed - Balto.			City Employee	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland					Balto. City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3012 Ferndale Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
(dec.) George Richard Carr			(dec.) Daniels, Mary Alice						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			213-30-7388		Records: Spring Grove State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATCVD</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
443X Carcinoma of tongue									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 23, 19 67, to 7/10, 19 68, that (I) (we) saw the deceased alive on 7/10, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Fisher</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/10/68			
22d. PHYSICIAN'S NAME (Type) Robert Fisher, M.D.				22e. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-13-1968		Western		Baltimore Md.			
24. FUNERAL DIRECTOR G. Howard Strong				ADDRESS 3207 W. North Ave.,		25a. REC'D BY REGISTRAR DATE JUL 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02210

10331

RECORDS OF DEATH

George Henry

White

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09523

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09532

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>LOLA PEARL CHENOWETH</b>			2a. DATE OF DEATH Month Day Year <b>July 11, 1968</b>			2b. HOUR <b>7.45 PM</b>			
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH <b>April 11, 1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8025 Highpoint Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>schoolteacher:retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8025 Highpoint Road</b>	
14. FATHER'S NAME First Middle Last <b>Franklin McDaniel</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Olive ?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16b. SOCIAL SECURITY NO. <b>234-32-0046</b>		17. INFORMANT Address <b>Floyd D. Chenoweth 8025 Highpoint Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the Breast</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases to bones</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Dec 1959</b> <b>1965</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>170X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 5</b> , 19 <b>57</b> , to <b>July 11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>July 11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>E. J. Alessi M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED <b>7/12/68</b>									
22d. PHYSICIAN'S NAME (Type) <b>E. J. Alessi, M.D.</b>		22e. ADDRESS <b>6217 Harford Rd, Balto, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>7-15-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodsdale Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Grafton, W. Va.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc Baltimore, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR			
BOK			LEIT		CHEW		(Chin)		ESTIMATED MONTH DAY YEAR		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		
Male		Chinese		Mar. 3, 1913		55 YRS.						M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Canton, China			USA						Baltimore County					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Towson				St. Joseph's Hosp Restaurant										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.								Balto. City				2430 N. Charles Street		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
First Middle Last					First Middle Last									
UNKNOWN					UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT family, etc. ADDRESS				
YES					WW II					213-26-7505 Wai Wan Chew (wife), 2430 N. Charles St., Balto., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion Sudden														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
4201														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Charles F. O'Donnell					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED 2/26/68				
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.					ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			July 25, 1968		Lorraine Park Cemetery Woodlawn, Balto. Co., Md.									
24. FUNERAL DIRECTOR					ADDRESS					25a. FILED BY REGISTERED				
STEWART & MOWEN CO. 108 W. North Av., City 1					Balto.					JUL 26 1968				
										25b. BY SIGNATURE				

48733

11522

NAME (PRINT) LAST FIRST MIDDLE

DATE OF BIRTH (MM/DD/YYYY)

CITIZENSHIP (e.g., U.S., Canadian, British, etc.)

PRESENT ADDRESS (Street, City, State, Zip)

TELEPHONE (Area Code, Number)

EDUCATION

EMPLOYMENT

REMARKS (e.g., Date of entry, purpose of visit, etc.)

STREET ADDRESS (e.g., 123 Main St., New York, NY 10001)  
CITY (e.g., New York)  
STATE (e.g., NY)  
ZIP (e.g., 10001)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09523											
09534											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Anna			Cieri						July Month 27 Day 1968 Year		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		March 24 1891		77 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		U.S.A.				BALTIMORE					
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE			SUMMIT NURSING HOME			TAILORING			CLOTHING		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MD.			BALTO		CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		SUMMIT AVE		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
PHILIP			GUGLIOTTA						JOSEPHINE VENTRI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			212-10-6399		Mrs. Austen Frederick			1244 Newfield Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>HEART DISEASE</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>HEART DISEASE</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>CHRONIC SHUNT BLOW</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>HEART DISEASE</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
422.1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/68</u> , 19 <u>68</u> , to <u>7/27/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/27/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
John H. Spaul								<input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
John H. Spaul						8700 ELMWOOD AVE CATONSVILLE, MD.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		7-30-68		Catholic Cem.		Baltimore				Md.	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Foley-Cunningham & Co. Catonsville, Md.								JUL 31 1968		J. Charles Judge	

2004-05-05

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First <b>WILBERT</b>		Middle <b>E.</b>		Last <b>CLARK</b>		2a. DATE KNOWN OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>9:50 P.</b>				
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>3/20/26</b>		6. AGE (in years) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month <b>7</b> Day <b>7</b> Year <b>1968</b>		2d. HOUR <b>9:50 P.</b>	
7a. BIRTHPLACE (State or foreign) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b>						
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>				11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <b>VET. ADM. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY _____				13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>717 PULASKI STREET</b>			
14. FATHER'S NAME First <b>WILL</b> Middle _____ Last <b>CLARK</b>			15. MOTHER'S MAIDEN NAME First <b>BLANCHE</b> Middle _____ Last <b>MARSHALL</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WN 11 220 12 75 77</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MARYLAND</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>946x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DECUBITIS ULCERS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>FRACTURED NECK</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>1 1/2 YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>962x</b>															
19a. DATE OF OPERATION <b>10/26/65</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>LAMINECTOMY</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>10/21</b> 19 <b>65</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fall from Couch while sleeping</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>434 E. Lafayette Avenue, Baltimore, Md. 21202</b>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>M B Davis</b>		EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M. D.</b>		6800 MORNINGTON ROAD, BALTO. MD. 21222		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/8/68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>									
24. FUNERAL DIRECTOR <b>MORTON &amp; DYETTE FUNERAL HOME</b>				ADDRESS <b>1701 Laurens St. Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

000332

000332

000332

000332

1 - 0

STANDARD COMPANY

U.S.A.

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A13-14  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09527									
09536									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Everett James Claudy						7 Month 13 Day 68 Year			11:30
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		3-15-14		54 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Virginia		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital city or address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		Great Balto. Med. Cent.		Mechanic		Transport.			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Balto.				21206 6804 Beech Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Everett Claudy			Mary Frederick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			233-01-8912		12 Patient's Chart 6701 N. Charles St. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>163x</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
5/7/68		Intractable back pain			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3/29</u> , 19 <u>68</u> , to <u>7/13</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>7/13</u> , 19 <u>68</u> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
EDWARD R. Soudijn									7/13/68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
EDWARD R. Soudijn					6701 N. Charles St. Balto. Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-17-1968		Gardens of Faith Cemetery		Baltimore Co. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Lassahn Funeral Home 7401 Belair Road 21236					DATE JUL 17 1968		J Charles Judge		

00000

00000

DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

EDWARD R. JORDAN  
R. Jordan



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First <b>John</b>			Middle <b>Fletcher</b>			Last <b>Cloman</b>			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/>	2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>7-27-85</b>	6. AGE (In years last birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/>		2d. HOUR M			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>							
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Kingsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 1, Box 688</b>				
14. FATHER'S NAME First <b>James</b>			Middle <b>Cloman</b>			Last <b>Agnes</b>			15. MOTHER'S MAIDEN NAME First <b>Moore</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no; or unknown) <b>NO</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217-48-8406</b>		17. INFORMANT ADDRESS <b>Helena Lebo 4205 Springwood Ave. 21206</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Cerebral damage</b>													
DUE TO, OR AS A CONSEQUENCE OF <b>Multifocal contusions of Brain</b>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>11 Day</b>													
DUE TO, OR AS A CONSEQUENCE OF <b>11 Day</b>													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8254 Generalized Arteriosclerosis</b>													
19a. DATE OF OPERATION <b>none</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>none</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>4:30 P.M. 7/16 1985</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Unintentional fall from ladder</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>			21f. LOCATION Street or R.F.D. No. City or Town and County State <b>Belair Rd South Sheradale</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>7/27/85</b>				
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Perry Hall Balto. Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/30/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Perry Hall Balto. Md.</b>				
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Rd.</b>						25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

10001

UNITED STATES DEPARTMENT OF AGRICULTURE

10001

(M)

3

5

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR	
ALBERT						COHN				July		18		1968		10 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
MALE	WHITE	1900		68 YRS.		MONTHS		DAYS		July		18		1968		M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								Md.	
RUSSIA		U.S.A.						BALTIMORE									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Pikesville		11 SLADE AVENUE, APT. 207		PROPRIETOR		WHOLESALE SHOES											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
MARYLAND		BALTIMORE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11 SLADE AVENUE, APT. 207									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
JACOB						COHN		MIRIAM						SAFFION			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		219-32-1754		MRS. ADELINE COHN, 11 SLADE AVE., APT. 207 #8													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4109</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
4201																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
none				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
none		19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
none																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		D. D. Caples		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		D. D. Caples, M. D.		6 Hanover Rd.		Reisterstown, Md.						7-18-68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
BURIAL		7-19-68		CHIZUK AMUNO (ARLINGTON)		BALTIMORE, MARYLAND											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				DATE		JUL 22 1968											

05558

1553

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

ALBERT WHITE

11 SLAVE AVENUE, APT. 202

BALTIMORE, MARYLAND

219-2-1771

11 SLAVE AVENUE, APT. 202

BALTIMORE, MARYLAND

219-2-1771

11 SLAVE AVENUE, APT. 202

BALTIMORE, MARYLAND

219-2-1771

11 SLAVE AVENUE, APT. 202

BALTIMORE, MARYLAND

219-2-1771

11 SLAVE AVENUE, APT. 202

BALTIMORE, MARYLAND

219-2-1771

11 SLAVE AVENUE, APT. 202

BALTIMORE, MARYLAND

219-2-1771

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												09539
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) <i>Benjamin Ignatius Cole</i>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>7</i> Day <i>15</i> Year <i>1968</i>			2b. HOUR <i>9:45</i> AM			
3. SEX <i>M</i>	4. RACE <i>C</i>	5. DATE OF BIRTH <i>4/25/08</i>	6. AGE (In years last birthday) <i>60</i> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>July</i> Day <i>5</i> Year <i>1968</i>			2d. HOUR <i>1:30</i> PM			
7a. BIRTHPLACE (State or foreign) <i>SPRINGFIELD, MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.						
10. CITY OR TOWN OF DEATH <i>Woodstock</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Woodstock College</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Gardner</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>WOODSTOCK</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>SUMMIT AVE</i>			
14. FATHER'S NAME First <i>MORTIMER</i> Middle <i>COLE</i> Last				15. MOTHER'S MAIDEN NAME First <i>MARY JOSEPHINE</i> Middle <i>SMALLWOOD</i> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>ALICE CAMPBELL 415 LYNDAHURST ST</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Primary site Unknown</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1992</i>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>James N. Frederick</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>7/15/68</i>				
EXAMINER'S NAME (Type) <i>James N. Frederick</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <i>1311 Francis Ave Balto. Md 21227</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>7/8/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST ALPHONSUS</i>			23d. LOCATION (City or Town) (County) (State) <i>WOODSTOCK MD</i>					
24. FUNERAL DIRECTOR <i>Marshall P. Shyne 635 N. Groomer St Balto MD</i>						25a. REC'D BY REGISTRAR <i>JUL - 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



03233

RECEIVED EXAMINER'S OFFICE

1964

RECEIVED



100-0-343



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09531

09540

1. DECEASED-NAME (Type or print) <b>ELMER</b>		First Middle Last <b>Louis COLE, Sr.</b>		2a. DATE OF DEATH Month Day Year <b>7/25/68</b>			2b. HOUR <b>10 A M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 13, 1895.</b>		6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8208 Harford Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired-Transit Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Pkville.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8208 Harford Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Lewis Cole</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Mae Dodge</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-03-2263A</b>		17. INFORMANT Address <b>Mr. Elmer Cole, Jr. 2614 Kentucky Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pancreatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>157.9</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few months</b> <b>undet.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157 X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 22, 1968</b> , to <b>July 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>22 July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Dr. Koss has been in constant attendance last yr.</b>									
22b. SIGNATURE <b>John C. Hyle</b>		22c. PHYSICIAN'S NAME (Type) <b>John C. Hyle</b>		22d. ADDRESS <b>M.D. 7527 Belair Road</b>		22e. DATE SIGNED <b>7/25/68.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/29/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore Md. 21214</b>				25a. REC'D BY REGISTRAR <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

03330

OFFICE OF THE

03331

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09533

09541

1. DECEASED-NAME (Type or print) <b>HIRAM</b>			First Middle Last <b>--</b>			2a. DATE OF DEATH Month Day Year <b>JULY 5, 1968</b>			2b. HOUR 2:50 P. M.		
3. SEX <b>MALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>10 5 98</b>			6. AGE (In years last birthday) <b>69</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMINISTRATION HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>935 E. MADISON STREET</b>			14. FATHER'S NAME First Middle Last <b>CHARLES COLEMAN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>LORETTA JACKSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> <b>YES WW-1</b>			16b. SOCIAL SECURITY NO. <b>217 01 3668</b>			17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>4329</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ENCEPHALOMALACIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>THROMBOSIS OF RIGHT CAROTID ARTERY</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  <b>weeks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>332 X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 4</b> , 19 <b>68</b> , to <b>July 5</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mario C. Quiros</i> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>July - 6<sup>th</sup> / 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>MARIO C. QUIROS, M.D.</b>						22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR <i>Joseph B. Locke Jr.</i>				ADDRESS <b>Joseph Locke</b> <b>1304 Central Ave.</b> <b>Baltimore, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

14380

14380

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (7)  
304 REV. 1-68

09533		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09542		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR MO
WILLIAM CARROLL COMEGYS						7 8 68		11 30
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		WHITE		7-27-68 1888		79 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
BALTIMORE MD		U.S.A.				BALTIMORE		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE, MARYLAND		6701 N. Charles ST		Service man		SINCLAIR OIL		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD				BALTO.				2007 LYDONLEA WAY
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last		
GEORGE R. COMEGYS						BROOKS MATILDA COMEGYS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES		1917		216-05-2585 MEDICAL RECORD CHART				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 571.9 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. 587.0 BRONCHOPNEUMONIA & SEPTICEMIA (b) DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOTIC LIVER								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6-08-68, 19 68, to 7-08, 19 68, that (I) (we) last saw the deceased alive on 7-08, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE M.N. Al-Mumayez		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-09-68		
22d. PHYSICIAN'S NAME (Type) M.N. AL-MUMAYEZ		22e. ADDRESS 6701 N. CHARLES STREET						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		7-11-68		Loudon Park Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...		

08328

08328

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1900

ALBANY

1901

PRINTED BY

THE STATE PRINTING OFFICE

ALBANY

1901

1901

1901

1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>09534</div> <div>CERTIFICATE OF DEATH</div> <div>09543</div>									
1. DECEASED-NAME (Type or print) First Middle Last <b>Blanche Lavesta Cook</b>						2a. DATE OF DEATH 7 Month 13 Day 68 Year		2b. HOUR 10 pM	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>3-31-1904</b>		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Great. Balt. Med. Cen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Ilchester Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Jotham Watson</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Blackburn</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>21-14-2949</b>		17. INFORMANT Address <b>21204 Patient's Chart 6701 N. Charles St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Oedema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Menengioma of Posterior Fossa</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Two Days</b> <b>One Year</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>223X</b>									
19a. DATE OF OPERATION <b>7-11-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(R) cerebellar/Tumor</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 27</b> , 19 <b>68</b> , to <b>7 13</b> , 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 13</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <b>Sabanayagam. H.D.</b>				22c. DATE SIGNED <b>July 13 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Dr. P. Sabanayagam M.D.</b>			
22e. ADDRESS <b>6701 N. Charles St. Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/16/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baptist</b>		23d. LOCATION (City or Town) <b>Harford</b> (County) <b>Harford</b> (State)			
24. FUNERAL DIRECTOR <b>Charles E. Kurtz Jarrettsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

107



107



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09535

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09544

1. DECEASED-NAME (Type or print) <i>Santa F. Costa</i>			2a. DATE OF DEATH <i>7</i> <i>15</i> <i>1968</i> Month Day Year			2b. HOUR M						
3. SEX <i>F</i>		4. RACE <i>ITALIAN-W</i>		5. DATE OF BIRTH <i>12/23/1870</i>		6. AGE (In years last birthday) <i>97</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>ITALY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MISIA/ Baltimore</i> Md.						
10. CITY OR TOWN OF DEATH <i>Catonsville BALTIMORE/MDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>CATON RIDGE NURSING HOME</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>15 S. East Ave. formerly</i>		
14. FATHER'S NAME First Middle Last <i>Emmanuel Ferrara</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>unknown</i>				16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Joppatown, Md. 27085</i> <i>Mr. Salvatore Costa 704 Ferguson Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4129</i> IMMEDIATE CAUSE (a) <i>Arteriosclerosis Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4200</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic congested heart failure</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>July 3</i> , 19 <i>68</i> , to <i>July 5</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>J. David Nagel</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>July 15 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>J. David Nagel, M.D.</i>						22e. ADDRESS <i>Caton Ridge Nursing Home 329 Harlem Lane</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/18/'68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>				
24. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Baltimore St.</i>						25a. REC'D BY REGISTRAR <i>JUL 17 1968</i> 25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>						

08224

CERTIFICATE OF DEATH

08224

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>09536</div> <div>CERTIFICATE OF DEATH</div> <div>09545</div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR a
John			Arthur Cotner			7 Month 15 Day 68 Year			8:20 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		2-9-95		73 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Retired		Sacred Heart Church			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Baltimore				1637-A Waverly Way 21212	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Arthur			Catherine			Hollister			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			178-05-2809		Mrs. Florence M. Cotner (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon with metastasis</u>									
1538 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>to liver.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1538									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 24</u> , 19 <u>68</u> , to <u>July 15</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 15</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Christine Feliciano, M.D.</u>									7-15-68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Christine Feliciano, M.D.					7620 York Rd. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/18/68.		Balto. National Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS					25. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Balto. Md. 21214					JUL 16 1968		<u>Charles Judge</u>		

08345

(M)

1

1000 1000 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09546		
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Elizabeth Pearl Coulbourn						July Month 20 Day 68 Year			M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		April 16, 1905			63 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Florida		USA					Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville Manor			1119 Daniel Ave.			House Wife			Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Baltimore		Catonsville				1119 Daniel Ave.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
John B. Owens			Martha Robinson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No			No		262.03.5132		Mr. Thomas E. Coulbourn Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion										6 hours		
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease										1 year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 42201 DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypothyroidism, severe												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 19 48, to July 19 68, that (I) <del>was</del> saw the deceased alive on July 20, 19 68 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.												
22b. SIGNATURE		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		1811 N. Rolling Road Balto. Md.		22e. ADDRESS		July 22, 1968						
22d. PHYSICIAN'S NAME (Type)		Millard T. Traband, Jr.		22e. ADDRESS		1811 N. Rolling Road Balto. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		7/24/1968		Lorraine Park		Woodlawn Baltimore Md.						
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
John T. Stansbury		6411 Windsor Mill Rd.		JUL 23 1968		Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

09533		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09547		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print) <b>WAVERLY</b>			First	Middle	Lost	2a. DATE OF DEATH <b>JULY</b> Month <b>13</b> Day <b>1968</b> Year		2b. HOUR <b>9:05</b> M
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>4/15/12</b>		6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>Fort Howard</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Vets. Admin. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1623 N. Broadway</b>
14. FATHER'S NAME <b>Weldon Cox</b>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Martha Neal</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>217-09-44-38</b>		17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST DUE TO ACUTE MYOCARDIAL INFARCTION</b> MINUTES <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>GENERALIZED ARTERIOSCLEROSIS WITH COMPLETE</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <b>OCCLUSION OF RIGHT FEMORAL ARTERY</b> YEARS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1968</b> , to <b>July 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 13, 1968</b> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above <b>(I) (we) (did) (did not) view the body after death.</b>								
22b. SIGNATURE <b>Pushpendra Senan M.D.</b>						22c. DATE SIGNED <b>7/13/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>PUSHPENDRA SENAN, M.D.</b>						22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>ELLIOTT FUNERAL HOME</b>				ADDRESS <b>1129 N. Caroline St. Baltimore, Md.</b>		25a. RECD BY REGISTRAR <b>JUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

08247

08247



RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY FOR  
GENERAL AFFAIRS  
MAIL ROOM  
MAIL STOP 100  
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

BP

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
EDWARD			LEWIS	CROMWELL		JULY 16 1968			5:00AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		NEGRO		4/16/18		50 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
MARYLAND		U.S.A.				BALTIMORE COUNTY,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ADM. HOSPITAL			TRUCK DRIVER			CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased admission)			13b. CITY OR TOWN lived, if institution: Residence before			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND			BALTIMORE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		HEREFORD ROAD			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
HORACE			E.	CROMWELL		GRACE			WHYE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
YES			WW II			212 14 13 12			CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NEPHROSCLEROSIS, TYPE UNDETERMINED. DIABETES MELLITUS, CLINICAL</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/4/68</u> , 19 <u>68</u> , to <u>7/16/68</u> , 19 <u>68</u> , that <u>48</u> (we) last saw the deceased alive on <u>7/16/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Rodolfo G. Miro</u>										7/16/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
RODOLFO G. MIRO, M. D.						VAM FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
		7/20/68		ST. LUKE'S UNITED CEMETERY		MONKTON, MARYLAND					
24. FUNERAL DIRECTOR						ADDRESS		25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						CHATMAN FUNERAL HOME		JUL 22 1968		<u>Charles Judge</u>	
						1701 McCullough St. Baltimore, Md.		27217			



88558

1117

1000 8:00 PM

RECEIVED

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Hazel			Morgan Crowther			July 11 1968		4 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		July 27, 1891		76 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Penna		U.S.A.				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Dundalk			4 Eastship			At home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 Eastship	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Robert Morgan			Gertrude Letiz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No					Mrs. Gertrude Buzzell, 4 Eastship					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of LARGE bowels (Colon)</u> 1538 DUE TO, OR AS A CONSEQUENCE OF <u>Metastasis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ORIGINAL OPERATION JAN. 1961 =</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>line</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>line</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Oct-67		Bowel Obstruction			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1967</u> , to <u>July 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>M.B. Davis</u>					22c. DATE SIGNED JULY 12, 1968					
22d. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.					22e. ADDRESS 6800 Mornington Road					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 13, 1968		Meadow Ridge		Dorsey, Md.				
24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.				25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

08380

0272



08380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09542

09550

1. DECEASED-NAME (Type or print) <b>Myron Stirling Curry</b>			2a. DATE OF DEATH <b>July</b> Month <b>1</b> Day <b>1968</b>			2b. HOUR <b>11:30</b> PM					
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>March 20, 1887</b>		6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Towson Conv. Home.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Postal Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Mail</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto</b>			13c. CITY OR TOWN <b>White Hall</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER _____	
14. FATHER'S NAME First <b>Alfred W.</b> Middle <b>Curry</b> Last _____			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>A.</b> Last <b>Quigley</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>213-16-9564</b>			17. INFORMANT <b>Martha J. Leffel, White Hall, Md.</b>			Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G.D. C.V. disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1/68</b> , 19 <b>68</b> , to <b>7/1/68</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>7/1/68</b> , 19 <b>68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <b>A. M. France</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/2/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>						22e. ADDRESS <b>PARKTON, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Liberty Cem.</b>			23d. LOCATION (City or Town) _____ (County) <b>Balto.</b> (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>James Hartenstein, New Freedom, Pa.</b>						ADDRESS _____		25a. REC'D BY REGISTRAR <b>JUL - 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

12500

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

12500

Division of the Census

Office of the Director

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

Mr. J. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First JOHN			Middle G.			Last DABRASKY			2a. DATE OF DEATH Month Day Year July 12 1968			2b. HOUR 8:30 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 18, 1876			6. AGE (In years last birthday) 92 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.								
10. CITY OR TOWN OF DEATH Baltimore County			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines 16 Fusting Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CASHIER			12b. KIND OF BUSINESS OR INDUSTRY Banking								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY — ✓			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 18 S. Monroe Street					
14. FATHER'S NAME First Middle Last GEORGE Dabarsky			15. MOTHER'S MAIDEN NAME First Middle Last Augusta Schmeltz														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) NONE 217-07-1518			17. INFORMANT Address Sophia Dabarsky, 18 S. York St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)												3-4 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332x Arterioscl. cardio vas disease																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from July 3, 1968, to July 12, 1968, that (I) (we) last saw the deceased alive on July 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Thomas Chudoba M.D.			22c. DATE SIGNED 7.13.68			22d. PHYSICIAN'S NAME (Type) T. KUPIRKA			22e. ADDRESS 2151 Wilkens Ave								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7-16-68			23c. NAME OF CEMETERY OR CREMATORY Haddon Park			23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.								
24. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home Francis W. Miller 2101 Frederick Ave			25a. REC'D BY REGISTRAR JUL 15 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

## STATEMENT OF DEBIT

DATE: 10/10/10  
TO: 10/10/10  
FROM: 10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09543										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09552									
Item 6 film G 402 7/24/68 11w										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Rev. Pierce Thomas Dalton SSJ										7 16 1968					12:15AM														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			WHITE			6/12/03			64 65 YRS.			MONTHS DAYS			HOURS MIN.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Stoneham, Mass.					U.S.										Baltimore Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
TOWSON					St. Joseph's Hospital					Clergyman																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
STATE Maryland										Baltimore					YES <input type="checkbox"/> NO <input type="checkbox"/>					1130 N. Calvert Street									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
RICHARD DALTON					MARY BRYANT																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
Yes, no, or unknown										FATHER ODEA					1130 N. Calvert St														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Metastatic brain tumor																													
1621 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) Carcinoma of the left lung																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
163X																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1968, to July 16, 1968, that (I) (we) last saw the deceased alive on July 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED									
Dr. R. Radmenesh																				7-16-68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
R. Radmenesh, M.D.															7620 York Rd. Towson, Md. 21204														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					7/19/68					Cathedral					Baltimore Md.														
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
Joseph B. Locks										1304 N. Central Ave					JUL 22 1968					J. Charles Judge									

09222

09222



1952 JAN 13

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]



1952 JAN 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09544					09553				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville 21087</b> c. LENGTH OF STAY IN 1b <b>21087</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ruxford Drive</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville 21087</b> d. STREET ADDRESS <b>Ruxford Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Elsie May Davis</b>			4. DATE OF DEATH <b>July 11 1968</b>		5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 14, 1909</b> 9. AGE (in years last birthday) <b>59</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. Kugel</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Cox</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-14-5635</b>		17. INFORMANT <b>Mrs. Alice Wettengel</b> Address <b>(Same)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of lung, liver, spine</b> 174X DUE TO (b) <b>Carcinoma of breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>170X</b>								INTERVAL BETWEEN ONSET AND DEATH <b>7 mos 1 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> , 19 <b>68</b> , to <b>7/11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/11</b> 19 <b>68</b> , and that death occurred at <b>6:28</b> PM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Phyllis K. Pullen</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/11/68</b>			
22c. PHYSICIAN'S NAME (Type) <b>Phyllis K. Pullen</b>				22d. ADDRESS <b>Kingsville, Md. 21087</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

10253  
1144  
10253  
1144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Helen			J.		Davis		July		8 Day		68 Year		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS	
Female			white			NOV. 27, 1888			79 YRS.			IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
PA.			U.S.A.						Baltimore Co.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville			Summit Nursing Home			Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			BALTO			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			919 Sedgley Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Albert Smith			Mary Wasser										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No			NONE			Mary E. Goetsch, 919 Sedgley Rd. Balto 21228							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardio-vascular disease										8/1/68			
DUE TO, OR AS A CONSEQUENCE OF (b) Gradual deterioration following													
DUE TO, OR AS A CONSEQUENCE OF (c) Multiple surgery - cancer													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
Carcinoma Splenic Flexure Colon													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
5/1/68			Carcinoma Colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year										
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>						Street or R.F.D. No.							
22a. I certify that (I) (this hospital) attended the deceased from 4/10/68, 19__, to 7/8/68, 19__, that (I) (we) last saw the deceased alive on 6/22/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
B. Martin Middleton MD			7/8/68										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
B. Martin Middleton MD			3320 Wilkens Ave Balto										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			7-11-68			Shenango Valley Cemetery			Greenville, Pa.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Howard H. Hubbard, 4107 Wilkens Ave. Balto.						JUL 10 1968			Charles Judge				

520

1999



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
00546 CERTIFICATE OF DEATH 09555																		
1. DECEASED-NAME (Type or print)			First <b>WILLIAM</b>		Middle <b>-</b>		Last <b>DAVIS</b>		2a. DATE OF DEATH Month <b>7</b> Day <b>15</b> Year <b>68</b>		2b. HOUR <b>4:10P M</b>							
3. SEX <b>MALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>5/6/92</b>			6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b>			Md.						
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LONGSHOREMAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1020 RUTLAND AVENUE</b>								
14. FATHER'S NAME First <b>GUS</b>			Middle <b>DAVIS</b>			Last <b>DAVIS</b>			15. MOTHER'S MAIDEN NAME First <b>KATIE</b>			Middle <b>FLOYD</b>			Last <b>FLOYD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b>			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>WW I</b>			17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>151.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>151.9</b> (b) <b>ADENOCARCINOMA OF STOMACH WITH WIDESPREAD METASTASES</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <b>ADENOCARCINOMA OF PROSTATE WITH METASTASIS. ARTERIOSCLEROTIC HEART DISEASE</b>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>6/6/68</b> , 19 <b>68</b> , to <b>7/15/68</b> , 19 <b>68</b> , that <b>he</b> (we) last saw the deceased alive on <b>7/15/68</b> , 19 <b>68</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <b>Peter Juvan</b>			DEGREE <b>PETER V. JUVAN, M. D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>7/16/68</b>								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>															
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>			23b. DATE <b>7-19-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>									
24. FUNERAL DIRECTOR			ADDRESS <b>JOSEPH KNIGHT FUNERAL HOME</b> <b>1639 N. Broadway, Baltimore, Md.</b>												25a. REC'D BY REGISTRAR DATE <b>JUL 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03538

03538

DAVID - LALAN

TO - FROM

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

DAVIDSON COUNTY - A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First WILLIAM		Middle S.		Last DEY		2a. DATE OF DEATH Month Day Year July 11 1968		2b. HOUR 8:p M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH September 28, 1897		6. AGE (in years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Purchasing Agent Oil Co.		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 940 Dulany Valley Rd. 21204		
14. FATHER'S NAME First Middle Last William M. Dey		15. MOTHER'S MAIDEN NAME First Middle Last Anna C. Davis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WW1 214-01-4240		17. INFORMANT Mrs. Helen M. Dey		Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 5191 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 5272										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 1968, to <u>July 11</u> , 1968, that (I) (we) last saw the deceased alive on <u>July 11</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. R. Radmanesh</u>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/11/68.
22d. PHYSICIAN'S NAME (Type) Ramezanali Radmanesh, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/68.		23c. NAME OF CEMETERY OR CREMATORY Mt. Maria Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 12 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

08256

11556



*Handwritten signature or initials*

*Handwritten text at bottom left*

*Handwritten text at bottom right*

09548 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09557

FOR STATE  
HEALTH DEPT.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR		
EDWARD			L.			DISNEY			July 6 1968			3:30 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	July 31, 1932	35 YRS.					Month Day Year			3:30 P.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			USA						Towson Baltimore,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Towson			St. Joseph Hospital			Howard Johnson Plant								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			BALTO			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			9840 Magledt Rd 21234		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last					
Edward			L. Disney Sr.			Leona			M. Klebe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			219-30-7609			Mrs Mary E. Disney			9840 Magledt Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshe wound of Brain</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>976X</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Family Permission <input checked="" type="checkbox"/>		
June 26, 1968			Same as above											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>26 June 68</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>22 Cal Bullet Fired into Skull</u>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u>Home - 9840 Magledt Rd 21234</u>								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>7/6/68</u>		
EXAMINER'S NAME (Type)			Charles F. O'Donnell, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			7-9-1968			St. John's Cemetery			Baltimore Co. Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
<u>Starky J. Jones</u>			<u>7401 Belair Rd.</u>			JUL - 9 1968			<u>Charles Judge</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08521

08521

RECEIVED BY NINTH - CERTIFICATE OF DEATH

FOR FILE



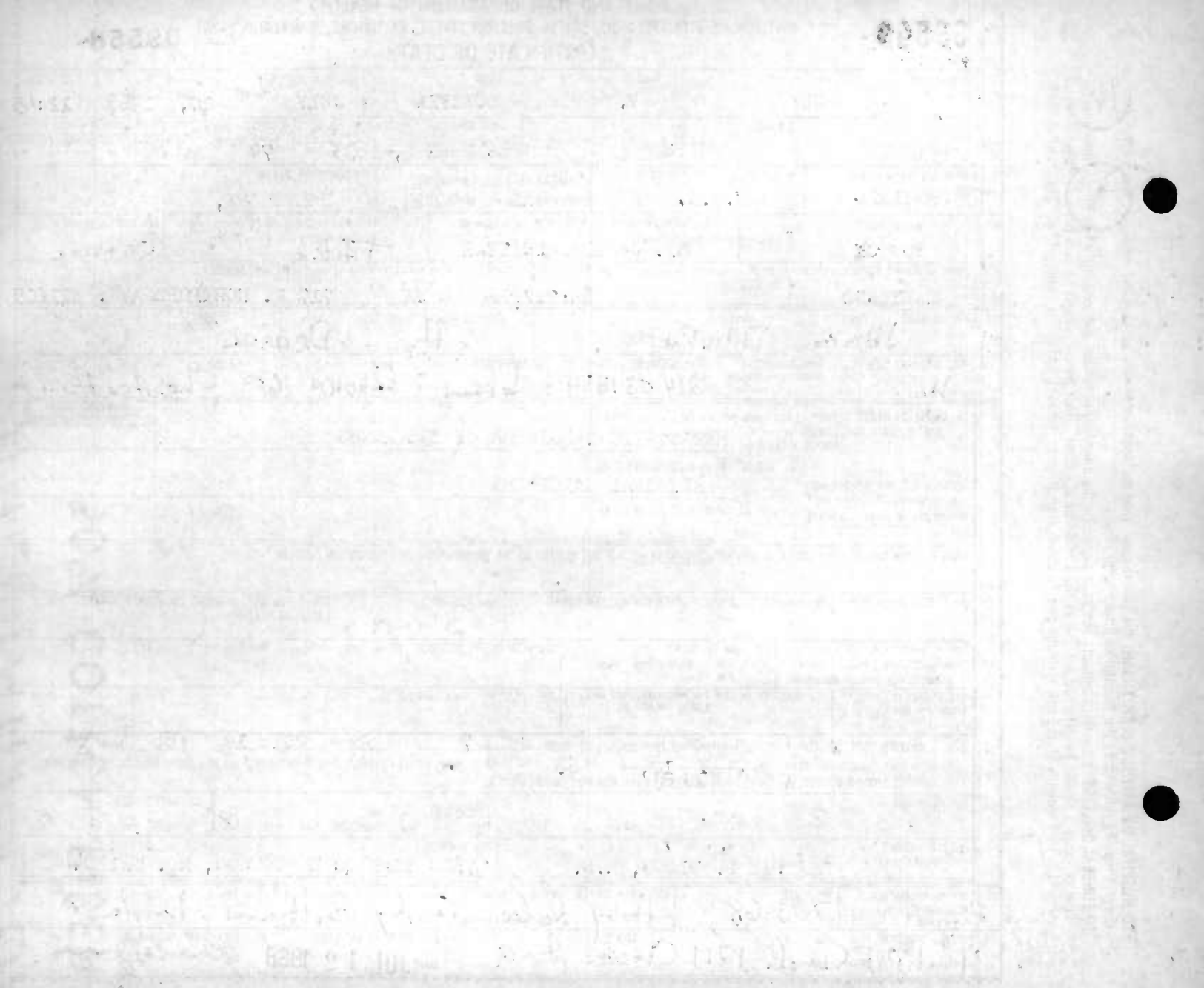
3-11-1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First JOHN		Middle V.		Last DOLIVKA		2a. DATE OF DEATH Month Day Year JULY 10, 1968	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 8, 1893			6. AGE (In years last birthday) 74 YRS.		2b. HOUR 12:45	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, Md.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tailor			12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 717 N. MONTFORD AVE. #21205		
14. FATHER'S NAME James Dolivka			15. MOTHER'S MAIDEN NAME Anna PRASAL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 214 031554			17. INFORMANT Jerome F. Dolivka 1613 Chosaco Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE LUNGS DUE TO, OR AS A CONSEQUENCE OF (b) LARYNGEAL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (X) (this hospital) attended the deceased from JULY 7, 1968, to JULY 10, 1968, that (X) (we) last saw the deceased alive on JULY 10, 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE Beatriz P. Dizon					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 10, 1968	
22d. PHYSICIAN'S NAME (Type) BEATRIZ P. DIZON, M.D.					22e. ADDRESS 7620 YORK ROAD TOWSON, MD. #21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-13-68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeem Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Philip F. Truch 1211 Chosaco Ave.					25a. REC'D BY REGISTRAR DATE JUL 12 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First HARRY		Middle A.		Last DOLLE		2a. DATE OF DEATH Month Day Year July 24, 1968		2b. HOUR 4:00 A M		
3. SEX male		4. RACE white		5. DATE OF BIRTH June 3, 1888			6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.							
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Fire Chief			12b. KIND OF BUSINESS OR INDUSTRY City					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. 4602 Manordene Rd. Balto. Md.		13b. COUNTY 21229		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4602 Manordene Rd.					
14. FATHER'S NAME First Middle Last John H. Dolle			15. MOTHER'S MAIDEN NAME First Middle Last Augusta Boecher			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no				16b. SOCIAL SECURITY NO. (If give war or dates of service) 219-36-0996		17. INFORMANT Address John H. Dolle, son, 813 Branford Circle 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CV DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) STROKE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 1948, to 7/24, 1968, that (I) (we) lost saw the deceased alive on 7/20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. Thomas E. Roach		22c. DATE SIGNED 7/25/68		22d. PHYSICIAN'S NAME (Type) Dr. Thomas E. Roach		22e. ADDRESS 5550 Baltimore National Pike		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/27/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge									

03753

03753

03753

THE NATIONAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

U. S. DEPARTMENT OF JUSTICE

INVESTIGATION OF THE ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

AND THE ASSOCIATED ACTS OF VIOLENCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Vera E. Donaldson						July 26 1968			M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F	W		4/8/03			65 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		1436 Forest Park Ave		Clerk		U. S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Baltimore				2 N. Tremont Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Lawrence Carney			Louise Carney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			213-20-9554		Mrs. Elizabeth Peters, 1436 Forest Park Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ 4129 DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 1953, to July 26, 1968, that (I) (we) lost saw the deceased alive on July 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Nelson McKay, Dr.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 26, 1968
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
J. Nelson McKay, Dr.					6014 Edmondson Ave., 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/29/68		Baltimore, National Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229					25a. BY REGISTERED STRA DATE		25b. REGISTRAR'S SIGNATURE J. Nelson McKay		
					JUL 30 1968				

30722

30722

1975-01-15/16

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20

1968-01-20



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Margaret Frances Dorsey</i>					2a. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>68</i>			2b. HOUR M <i></i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>April 10, 1904</i>		6. AGE (In years last birthday) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Owings Mills</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>10711 Reisterstown Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Owings Mills</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10711 Reisterstown Road</i>	
14. FATHER'S NAME First Middle Last <i>Edgar B. Shipley</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Alice E. Etchison</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)		16b. SOCIAL SECURITY NO. <i>213-01-2429</i>		17. INFORMANT Address <i>Mrs. Margaret F. Knott Owings Mills, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>1538</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Colonic Adenocarcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7/29 - 7/30/68</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>1538</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/20</i> , 19 <i>68</i> , to <i>7/30</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>7/30</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death. <i>4:40pm</i>									
22b. SIGNATURE <i>Philip Bernstein</i> MD				DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>8/1/68</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Aug. 2, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Morgan Chapel</i>		23d. LOCATION (City or Town) (County) (State) <i>Carroll Co. Md.</i>			
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>				ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03233

UNITED STATES OF AMERICA

11-11-11



11-11-11



11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>09552</span> <span>CERTIFICATE OF DEATH</span> <span>09562</span> </div>									
1. DECEASED-NAME (Type or print) <b>SOPHIA NANKIVEL DOUGHERTY</b>						2a. DATE OF DEATH <b>JULY 15 1968</b>		2b. HOUR <b>1:15 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASION</b>		5. DATE OF BIRTH <b>3/14/92</b>		6. AGE (In years last birthday) <b>76 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>301 WESTOWNE RD.</b>	
14. FATHER'S NAME First Middle Last <b>CUMMINS</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>JANE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL Records</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF <b>+ Cerebral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260x Broncho pneumonia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1968</b> , to <b>July 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>7/15 1968</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles C. Brown, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>July 16, 1968</b>					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>JULY 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>John Burns Sons</b>				25. REC'D BY REGISTRAR <b>Lowson</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

• • •

) .

$$= \frac{1}{2} \left( \frac{1}{2} + \frac{1}{2} \right) = \frac{1}{2}$$

ENFT-2

1. *Chlorophyll*

1. 1990

• • •

1999

3. 12

( )

1992

1

1000

1. 2. 3. 4. 5.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
PETER			-	-	DUDA	JULY 15, 1968			5:00AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		1/18/96		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
POLAND		U.S.A.				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD			VETERANS ADMIN. HOSPITAL			CARPENTER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND					BALTIMORE				258 S. DURHAM STREET
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
MARCILA			-	-	DUDA	JOSEPHA			- - KORTYKOWSKI
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES			WWI		218 01 64 52 CLINICAL RECORDS, VAH, FT. HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>YEARS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4300</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <u>NOV. 28, 1967</u> , to <u>JULY 15, 1968</u> , that <del>(X)</del> (we) last saw the deceased alive on <u>JULY 15, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (we) (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <i>John D. Talbert MD</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/15/68	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.						22e. ADDRESS VAH, FT. HOWARD, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		7-18-68		HOLY ROSARY CEMETERY		BALTO			
24. FUNERAL DIRECTOR <i>Edward J. Weber</i>						25a. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
WEBER FUNERAL HOME						BANK & CHESTER STS. BALTIMORE, MD.			

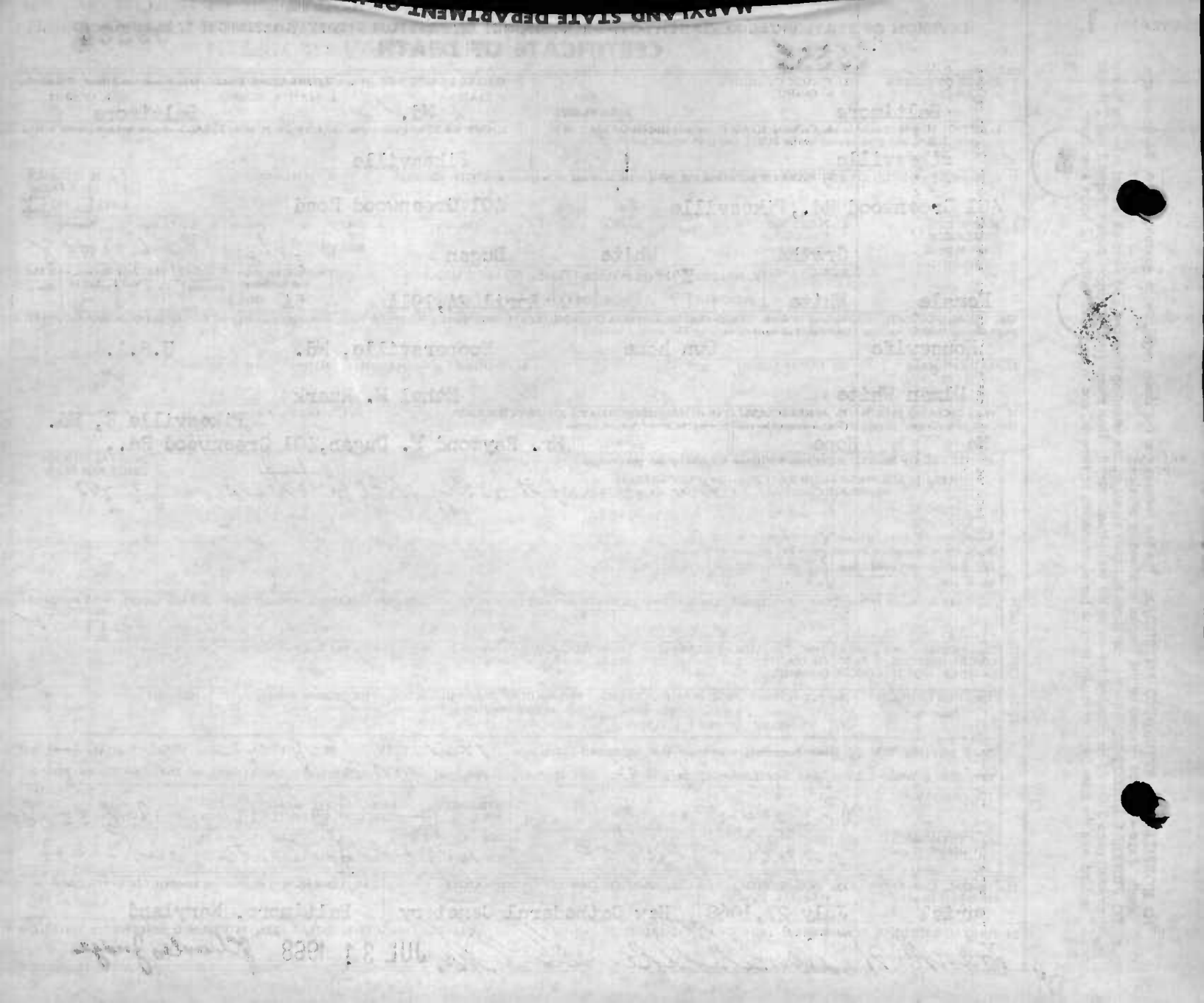




TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
09555  
09564  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 Greenwood Rd., Pikesville</b>		d. STREET ADDRESS <b>401 Greenwood Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gretha White Dugan</b>		4. DATE OF DEATH Month Day Year <b>July 26 1968</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1914</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hoopersville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ulman White</b>		14. MOTHER'S MAIDEN NAME <b>Ethel M. Ruark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>175.0</b>	
17. INFORMANT <b>Mr. Raymond F. Dugan, 401 Greenwood Rd., Pikesville 8, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of ovary with metastases</b> 183.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>175.0</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1957</b> , 19 to <b>July 26, 1968</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>July 26, 1968</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul H Royse</b>		22b. DATE SIGNED <b>July 26 1968</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul H Royse</b>		22d. ADDRESS <b>1403 Foley Ln Baltimore Md 21208</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 27, 1968</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville 8, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 31 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



3  
(M)  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09556

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09565

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR				
BERNARD					EAGLE	JULY 11 1968			7.15 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
MALE		NEGRO		8-29-1895		72 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
MD.		U.S.A.				Baltimore County, Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Mt. Wilson			Mt. Wilson State Hosp.			LABORER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MD.			—			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		224 OTTERBEIN ST.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
HENRY					EAGLE	ANNIE					HAWKINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT							
no			215-01-9227			Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute Hepatitis</u>													
570X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
580X (b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>Pulm. T-B For adenomyl. Active</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>5-10-</u> , 19 <u>68</u> , to <u>7-11-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-11-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>W. Newcomer</u>													
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
William Newcomer, M.D.								Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		7-17-68		Mt. Auburn		Balto. Md.							
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles A. Rice						661 W. Chase St.		JUL 16 1968		[Signature]			

03505

STATE OF TEXAS

1888

(M)

San Antonio County

of Wilson

County, Texas, Wilson County

County of Wilson, Texas

Wilson County, Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <i>Jean Elizabeth Ebersole</i>			2a. DATE OF DEATH Month <i>July</i> , Day <i>19</i> , Year <i>1968</i>			2b. HOUR <i>12:40 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>January 28, 1920</i>		6. AGE (In years lost birthday) <i>48</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Parkville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1624 Wentworth Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Advertising Co.</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1624 Wentworth Road</i>	
14. FATHER'S NAME First <i>Harry</i> Middle <i>D.</i> Last <i>Asher</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>A.</i> Last <i>Suttle</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>154-14-4546</i>			17. INFORMANT Address <i>Mr. David K. Ebersole, Jr. (Same)</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized metastatic Carcinoma</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of breast</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>170X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jaw</i> , 19 <i>63</i> , to <i>present time</i> , that (I) (we) last saw the deceased alive on <i>19 July</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Samuel E. Proctor M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>Samuel E. Proctor M.D.</i>						22e. ADDRESS <i>104 W. Madison St.</i>			
23a. BURIAL, CREMATION, or other disposal <i>Burial</i>		23b. DATE <i>7/22/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>						25a. REC'D BY REGISTRAR DATE <i>JUL 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(M)



(1)





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

09558												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												09567			
1. DECEASED-NAME (Type or print) First Middle Last MILDRED MARIE EDWARDS												2a. DATE OF DEATH Month Day Year 7 18 68								2b. HOUR 1A-M							
3. SEX FEMALE				4. RACE WHITE				5. DATE OF BIRTH SEPT. 20, 1916				6. AGE (In years last birthday) 51 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN							
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH BALTIMORE CO. Md.															
10. CITY OR TOWN OF DEATH RANDALLSTOWN				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8808 CHURCH LANE				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE				12b. KIND OF BUSINESS OR INDUSTRY															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY BALTIMORE				13c. CITY OR TOWN RANDALLSTOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 8808 CHURCH LANE											
14. FATHER'S NAME First Middle Last J. CLARENCE STOCKDALE				15. MOTHER'S MAIDEN NAME First Middle Last MARGARET H. SMITHSON																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown				16b. SOCIAL SECURITY NO. 213-24-9093				17. INFORMANT Smiley W. Edwards				Address Same address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 398X Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 416X																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 7/16, 1957, to 7/18, 1968, that (I) (we) saw the deceased alive on 7/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE M.J. Ellis				22c. DATE SIGNED 7/28/68											
22d. PHYSICIAN'S NAME (Type) M.J. Ellis				22e. ADDRESS Randallstown, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 7/20/68				23c. NAME OF CEMETERY OR CREMATORY ETERNGREEN MEM. GARDENS FINKSBURG, MD.				23d. LOCATION (City or Town) (County) (State) FINKSBURG, MD.															
24. FUNERAL DIRECTOR J. E. Meyer, Jr. Baltimore, Md.				ADDRESS				25a. REC'D BY REGISTRAR DATE JUL 23 1968				25b. REGISTRAR'S SIGNATURE Charles Judge															

03251

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

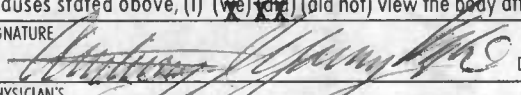
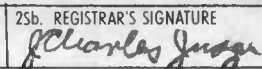
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Herbert</b>		First <b>Herbert</b>		Middle <b>Einhorn</b>		Last <b>Einhorn</b>		2a. DATE OF DEATH Month Day Year <b>July 2, 1968</b>			2b. HOUR p. M. <b>1:30 p.</b>						
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>March 16, 1914</b>			6. AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md.											
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>store owner</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Cheverly</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5825 Dewey Street</b>								
14. FATHER'S NAME <b>Henry Einhorn</b>			First <b>Henry</b>		Middle <b>Einhorn</b>		Last <b>Einhorn</b>		15. MOTHER'S MAIDEN NAME <b>Kate Lantz</b>			First <b>Kate</b>		Middle <b>Lantz</b>		Last <b>Lantz</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO. <b>577-12-6883</b>		17. INFORMANT <b>Records: Spring Grove State Hospital</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple sclerosis, far advanced.</b> <b>340X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>345X</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Decubitus Ulcers of buttocks, heels, arms; pyelonephritis, bilatera</b>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that I (this hospital) attended the deceased from <b>April 19, 1968</b> , to <b>July 2, 1968</b> , that I (we) lost saw the deceased alive on <b>July 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22b. SIGNATURE  DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7-2-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22e. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>									
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE 							

2252

00000

RECORDS OF DEATH

Married      Single      Divorced      Widowed      Unknown

Male      Female      Race      Birth Date      Birth Place

U.S.A.      Foreign      Birth Date      Birth Place

Married      Single      Divorced      Widowed      Unknown

Male      Female      Race      Birth Date      Birth Place

U.S.A.      Foreign      Birth Date      Birth Place

Married      Single      Divorced      Widowed      Unknown

Male      Female      Race      Birth Date      Birth Place

U.S.A.      Foreign      Birth Date      Birth Place

Married      Single      Divorced      Widowed      Unknown

Male      Female      Race      Birth Date      Birth Place

U.S.A.      Foreign      Birth Date      Birth Place

Married      Single      Divorced      Widowed      Unknown

Male      Female      Race      Birth Date      Birth Place

U.S.A.      Foreign      Birth Date      Birth Place

Married      Single      Divorced      Widowed      Unknown

Male      Female      Race      Birth Date      Birth Place

U.S.A.      Foreign      Birth Date      Birth Place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 113  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First CHARLES		Middle E.		Last ELMORE, Sr.		2a. DATE OF DEATH Month 12 Day 1988		2b. HOUR 6:35p M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH September 26, 1909			6. AGE (in years last birthday) 27 58 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) South Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Shipyard				
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Anne Arundel Co.			13c. CITY OR TOWN Glenburnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 706 Seagrove Rd.	
14. FATHER'S NAME Charles E. Elmore			15. MOTHER'S MAIDEN NAME Fannie Moseley										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Charles E. Elmore, Jr., same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 274X DUE TO, OR AS A CONSEQUENCE OF <u>Benign nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gout</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 288X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (H) (this hospital) attended the deceased from July 5, 1968, to July 12, 1968, that (X) (we) last saw the deceased alive on July 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Ines Cilliani			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED July 13, 1968				
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M. D.			22e. ADDRESS 7620 York Road, Towson 4, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 14 July 68			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.				
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.			ADDRESS			25a. REC'D BY REGISTRAR JUL 15 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

0350

0350





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Fred	Middle Whitman	Last Ensey	2a. DATE OF DEATH Month 7- Day 20- Year 1968			2b. HOUR 7A-M		
3. SEX M		4. RACE W		5. DATE OF BIRTH 2-2-1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? Baltimore		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cron dall, Owings Mills		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) V.P. Advertise Ret.		12b. KIND OF BUSINESS OR INDUSTRY & Co. McCormick					
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Owings		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Lot			Middle Ensey		Last Ensey		15. MOTHER'S MAIDEN NAME First Louisa			Middle Seth	Last Lowe
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 215-09-0819		17. INFORMANT Mrs. Etta B. Ensey			Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>188X</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma Urinary Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Generalized Arterio-Sclerosis</u> (b) <u>Unrepaired</u> DUE TO, OR AS A CONSEQUENCE OF <u>Stroke</u> (c) <u>1</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1810</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>36</u> , to <u>July 20</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. H. Woody</u> M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7-22-68</u>			
22d. PHYSICIAN'S NAME (Type) Dr. W. H. Woody				22e. ADDRESS 1403 Park Avenue Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-23-68		23c. NAME OF CEMETERY OR CREMATORY St. Thomas' Cemetery		23d. LOCATION (City or Town) Garrison Forest,		(County) Md.		(State) Md.	
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md.				ADDRESS 21212		25a. REC'D BY REGISTRAR DATE JL 22 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

07300

000 4 31 00

033



880 0 0 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 116  
30M REV. 11-68

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09562 CERTIFICATE OF DEATH 09571											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
HARRY A FARSON				A	FARSON	7-4-68			1:00 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
M		W		3-11-21			47 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
BALTO		U.S.A.				BALTIMORE					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
RANDALLS TOWN			BALTO. CO. GEN. HOSP.			MECHANIC					
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			BALTO			BALTO		YES <input type="checkbox"/> NO <input type="checkbox"/>		5408 MONTBEL AVE.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
HARRY A. FARSON						ANNA LAURA BROOKHEISER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT.					
YRS			WW II - 216-07-8008			MARJORIE N FARSON -					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular disease @ Coronary Dnsufficiency (c) Sudden 4/1/68										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
				9/28, 1958, to 7/4, 1968, that (I) (we) last saw the deceased alive on 7/7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eliot W. Johnson				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 7/5/68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 37 S. Frederick Ave Baltimore, Md 21229							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
BURIAL		7-8-68.		Woodlawn Cemetery				BALTIMORE, MD.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ellsworth Armacost-4600 Liberty Hghts. Ave								JUL - 5 1968		Charles Judge	

1764

3422

11-11-17

YOUNG AND LEE

[illegible]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
LILLIAN MAE FAUL						Month Day Year		682:50PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female	CAU	Nov. 16 1880	87 YRS			Month Day Year		68 4:15PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore		USA				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Essex (21)			1439 Galena Rd.			Housewife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Baltimore		Essex (21)				1439 Galena Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
John Root			Julia ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No			None		George Gouker		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 582X Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 593X AGVD										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			M.D.			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			Theodore Patterson, M.D. 105 Main St. Dundalk, Md. 21222			7/11/68				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		7/15/68		Baltimore Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Bruzdzinski Funeral Home 1407 Eastern Ave.					DATE JUL 15 1968		J Charles Judge			

08373

08373

MINERAL EXAMINER'S REPORT ON DEATH

11/11

11/11

Nov. 10 1900

Nov. 10 1900

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First Middle Last <b>Helen K. Fiege</b>			2a. DATE OF DEATH 7 Month 14 Day 68 Year		2b. HOUR 10:40
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4-26-1895</b>		6. AGE (In years lost birthday) <b>73</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore Md.</b>
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Great.Balt. Med. Cen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>8613 Chestnut Oak Rd. 21234</b>
14. FATHER'S NAME First Middle Last <b>John C. Fiege</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Katie</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-03-2676</b>		17. INFORMANT Address <b>Patient's Chart 6701 N. Charles ST. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE CARDIAC FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION (ACUTE and OLD)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days approx 3</b> <b>1 week approx</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 7</b> , 19 <b>68</b> , to <b>July 14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>July 14</b> , 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Duncan McGhie</b>				22c. DATE SIGNED <b>7/15/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DUNCAN MCGHIE</b>				22e. ADDRESS <b>616 E. 34<sup>th</sup> ST BALTIMORE MD 21218</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>7/16/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woburn Oaklawn</b>	
23d. LOCATION (City or Town) (County) (State) <b>Eastern Ave Balto. Md</b>					
24. FUNERAL DIRECTOR <b>WIEDEFELD</b>		ADDRESS <b>6500 YORK RD. BALTIMORE</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 16 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

08378

TESTIMONY OF JOHN

08378

08378

MYOCARDIAL INFARCTION (acute and old) (autopsy)  
CONGESTIVE CARDIAC FAILURE  
AGE-RELATED HEART DISEASE  
YEARS

YES

X

CIP E 34<sup>th</sup> ST BALTIMORE 10518  
X 7/12/88

DURHAM MCGHEE  
DURHAM MCGHEE

10518 BALTIMORE MD 10518  
10518 BALTIMORE MD 10518

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If death is pending, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>Albert</b>			First <b>Albert</b>			Middle <b>R.</b>			Last <b>Fillmore</b>		
2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b. HOUR <b>M</b>		2c. DATE ESTIMATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2d. HOUR <b>M</b>		2e. DATE NOTIFIED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2f. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6/15/10</b>		6. AGE (In years and birthday) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Edgemere</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7346 Geise Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired- Rheem's Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>EDGEMERE</b>			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
14. FATHER'S NAME <b>Elijah</b>			First <b>Elijah</b>			Middle <b>Fillmore</b>			Last <b>Bradley</b>		
15. MOTHER'S MAIDEN NAME <b>Wilhelmina</b>			First <b>Wilhelmina</b>			Middle <b>Bradley</b>			Last <b>Bradley</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>219-01-2920</b>			17. INFORMANT (Wire) <b>Mrs. Iva L. Fillmore, 7346 Geise Ave.</b>			ADDRESS <b>Balto. Md. 21219</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4/100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Theodore C. Patterson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>3724 Dundalk, Ave.</b>				22b. DATE SIGNED <b>July 8, 1968</b>			
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b>				M.D. <b>M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>7/9/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

4520

5252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>ISABELLE BETTY FISANICH</b>					2a. DATE OF DEATH Month <b>07</b> Day <b>28</b> Year <b>68</b>			2b. HOUR P <b>5:30M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>08-22-29</b>		6. AGE (In years last birthday) <b>38</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREATER BALTO. MED. CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9607 OAK SUMMIT AVE</b>		
14. FATHER'S NAME First <b>LAWRENCE</b> Middle <b></b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b> Middle <b></b> Last <b>BREWER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or both (If yes, give war or dates of service) <b>NO UNKNOWN</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>Peter Fisanich 9607 Oak Summit Avenue 34</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory insufficiency</b> <b>1538</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastases in the lungs and liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of the colon</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>153.8</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>6/22, 1968</b> , to <b>7/28, 1968</b> , that (I) (we) last saw the deceased alive on <b>7/28, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>ERS</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7/28/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>EDUARD R. SOUDIYN, M.D.</b>					22e. ADDRESS <b>GREATER BALTO. MED. CENTER 6701 N. CHARLES ST. BALTO., MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-31-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Lassahn Funeral Home 7401 Belair Road 21236</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



2022

25.895



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09576					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										09576					
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			X Month Day Year		2b. HOUR				
BROTHER LAWRENCE J. FITZPATRICK S.J.						7/9/1968					M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
MALE		WHITE		11/23/98		69 YRS.						19		M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
ENGLAND			U.S.A.						BALTIMORE						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
WOODSTOCK			WOODSTOCK COLLEGE			RELIGIOUS			SOCIETY OF						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
MD.			BALTIMORE									JESUS			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last												
THOMAS FITZPATRICK			MARGARET ROURKE												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
						REV. JOHN A. CONLIN S.J. COLLEGE			WOODSTOCK, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma metastatic - 1621 DUE TO, OR AS A CONSEQUENCE OF Lung Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		3 months 1 yr			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			Harold H. Burns MD.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED						
EXAMINER'S NAME (Type)			Harold H. Burns			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			7-12-1968						
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
						ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
BURIAL			7/13/68			WOODSTOCK COLLEGE			WOODSTOCK, BALTO. MD.						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
H. W. MEARS & SON			805 N. CALVERT ST.			JUL 15 1968			Charles Judge						

08376

01103

33 1951 63 SOUTH LAMBERT J. LESTERSON J.D.

ALL DATE 11/28/98

WOODSTOCK N.Y. 12424

WOODSTOCK COLLEGE LESTERSON J.D. 12424

WOODSTOCK N.Y. 12424

WOODSTOCK COLLEGE LESTERSON J.D. 12424

Rev. John A. Donahue S.J. Donahue

WOODSTOCK COLLEGE LESTERSON J.D. 12424

WOODSTOCK COLLEGE LESTERSON J.D. 12424

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00568

CERTIFICATE OF DEATH

09577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		d. STREET ADDRESS <u>Milvale Rd</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE C. FLANNERY</u>		4. DATE OF DEATH <u>7 3 1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Dogge</u>		14. MOTHER'S MAIDEN NAME <u>Anna Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-9118</u>	
17. INFORMANT <u>Forest Haven Nurs. Home</u>		Address <u>315 Ingleside Ave 21228</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE</u> DUE TO (c) <u>SPINAL INFARCTION RUTTER</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : a.m. : p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>68</u> , to <u>7-3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-3</u> 19 <u>68</u> , and that death occurred at <u>12:00</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John Shaw</u>		22b. DATE SIGNED <u>7/3/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Shaw</u>		22d. ADDRESS <u>5800 Edmondson Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-6-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hgwy., Baltimore, Md</u>		25a. REC'D BY REGISTRAR <u>JUL - 8 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

00000

UNITED STATES OF AMERICA

1900

THE SECRETARY OF THE INTERIOR

WASHINGTON, D. C.

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
NORA KATHLEEN FRANCK									THUR. Month 7 Day 25 Year 68			12nd		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		CAUCASIAN		MAY 17, 1903			65 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
IRELAND			U.S.A.						BALTIMORE Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON			GREAT. BALT. MED. CEN.			House wife			AT Home					
13d. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.			BALTIMORE			CITY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1115-5 CHARLES ST. 21230				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME					
JOHN			Toomey				JANE		COLLINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No -			391-05-7717			PATRICIA R. BURNS - (Daughter)			1115 S. CHARLES ST. 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) RESIRATORY FAILURE														
1621 DUE TO, OR AS A CONSEQUENCE OF														
(b) CA OF LUNG														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
163X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from 5/31, 19 68 to 7/25, 19 68, that (I) (we) lost saw the deceased alive on 7/25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Dr. Meshkinpour												7/25/68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
HOOSHANG MESHKINPOUR, M.D.			6701 N. CHARLES T											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
BURIAL			MON. July 29-1968		BALTO. U.S. 11947 L.G.			BALTO, Md.						
24. FUNERAL DIRECTOR			24a. CURTIS E. EVANS			24b. ADDRESS			25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Charles Evans - CHARLES ST - 21230			1400 S.			DATE JUL 26 1968			J Charles Judge					

8720

OFFICE OF THE

1977

OFFICE OF THE

OFFICE OF THE

1977

OFFICE OF THE

OFFICE OF THE

1977

OFFICE OF THE

OFFICE OF THE

OFFICE OF THE

OFFICE OF THE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115-14  
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09570									
09579									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
BENJAMIN			FINLEY			GAITHER			4:20A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		NEGRO		3/6/90		78 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ANNE ARUNDEL CO.		MARYLAND U.S.A.				BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
FORT HOWARD			VET. ADM. HOSPITAL			WELL DIGGER			WELL DIGGING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MARYLAND			ANNE ARUNDEL CO			SEVERN		ROUTE 2, BOX 211C	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
BENJAMIN H. GAITHER			RACHEL E. BROOKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
YES WW I			215 16 95 88			CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(b) CEREBRAL ARTERIOSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
BRONCHOPNEUMONIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NO AUTOPSY		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2/16/67, 19__, to 7/1/68, 19__, that (I) (we) last saw the deceased alive on 7/1/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)									7/1/68
JOHN D. TALBERT, M. D.									VAH FORT HOWARD, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL		7-3-68		BALTIMORE NATIONAL			BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Elmer O. Wilson					WILSON FUNERAL HOME ORLEANS ST. BALTIMORE, MD.		JUL - 2 1968		J. Charles Judge

45279

6637

DEPARTMENT OF DEATH

NAME: [illegible] BIRTH: [illegible] DEATH: [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

PLACE OF BIRTH: [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

DATE OF DEATH: [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

CAUSE OF DEATH: [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

DATE OF BURIAL: [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

NAME OF BURIAL PLACE: [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

NAME OF FUNERAL HOME: [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>KATIE</b>			First Middle Last <b>GARRETT</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>10:45</b>
3. SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>3/6/01</b>			6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUMMIT NURSING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5 GARRETT AVENUE</b>
14. FATHER'S NAME First Middle Last <b>Louis DENT</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Annie R. Weems</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-12-9555</b>		17. INFORMANT Address <b>Katherine Washington 1027 Brantley Avenue</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gang abscess, large at upper lobe</u> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia at upper lobe</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 mrs</u> <u>1 year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1621</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct, 1967</u> , to <u>July, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 22 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lewis P. Gundry</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-26-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>LEWIS P. GUNDRY</b>				22e. ADDRESS <b>3350 Wilkins Ave, Balt Md 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-27-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Arbutus, Maryland</b>		
24. FUNERAL DIRECTOR ADDRESS <b>CHARLES R. LAW FUNERAL HOME 802 MADISON AVE.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

015840

EXTRACT OF DATA

1770

67

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

EXTRACT OF DATA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09572

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09581

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Charles</i> First Middle Last		2a. DATE OF DEATH <i>July</i> Month <i>29</i> Day <i>1968</i> Year		2b. HOUR <i>2:30 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov. 20, 1882</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2145 Lorraine Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Baltimore Transit</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Woodlawn</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>2145 Lorraine Ave.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
14. FATHER'S NAME First Middle Last <i>Henry Geisel</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Miller</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (if unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213.10.2528</i>		17. INFORMANT <i>Mrs Rose E. Geisel</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> <i>1991</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1992</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Milton Schlenoff MD</i>		DEGREE		22c. DATE SIGNED <i>7/29/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Milton Schlenoff</i>		22e. ADDRESS <i>6410 Windsor Mill Road Balto. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8/1/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>	
24. FUNERAL DIRECTOR <i>John T. Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>		23d. LOCATION (City or Town) (County) (State) <i>Woodlawn Baltimore Md.</i>	
25a. REC'D BY REGISTRAR <i>JUL 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

STATE OF TEXAS

County of \_\_\_\_\_ State of Texas

Know all men by these presents, that \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas

do hereby certify that \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas

is the owner of the following described land, to-wit:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Olly Gerstenberg</b>					2a. DATE OF DEATH <b>7</b> Month <b>24</b> Day <b>68</b> Year			2b. HOUR <b>3:30</b> M		
3. SEX <b>F</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>7-22-1895</b>			6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hampton Apartments</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>204 Joppa</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Cohen</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Wollstein</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>129 12 9468</b>		17. INFORMANT Address <b>Gerl W. Ehrlich, Towson, Md. 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CARCINOMA</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163x</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/23/68</b> , 19____, to <b>7/24/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/23/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>T. C. Siwinski</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/25/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>T. C. SIWINSKI</b>					22e. ADDRESS <b>206 W. PENNA. AV. TOWSON MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook Brooks Towson, Towson, MD.</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

88380

4732

10-11-1940

7  
7  
7



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item #6, Film G403 7/31 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print) <b>EDNA I. GONCE</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>7</b> Day <b>24</b> Year <b>68</b>		2b. HOUR <b>M</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>July 26 1901</b>	6. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR MONTHS <b>6</b> DAYS <b>6</b>	IF UNDER 24 HRS. HOURS <b>6</b> MIN. <b>30</b>	2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>24</b> Year <b>1968</b>		2d. HOUR <b>9:30</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Parkville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9904 Magledt Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>At Home</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>9904 Magledt Rd.</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>Sparr</b> Last <b>Sparr</b>				15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>Donnelly</b> Last <b>Donnelly</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Family records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of <del>XXXX</del> lung</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of left breast</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b> <b>4 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>170X</b>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>7/24/68</b>		
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford rd.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

WASH.

July 10, 1911

Dear Sir:

Enclosed for you are

two copies of a report

on the subject of

the condition of

the soil in the

State of Texas.

The report was prepared

by the Agricultural

Experiment Station

at Austin, Texas.

I am, Sir, very

truly yours,

Very truly yours,

10385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
Fannie			C.	Gorman		July 22, 1968			3:25 a. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years birthday)		7. IF UNDER 1 YEAR		
female		white		Oct. 16, 1886		81		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U. S.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			practical nurse				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.					Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3012 Ferndale Avenue	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME				
George Carr						Mary Daniels				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes, no, or unknown			218-22-7617		Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a)								Bacteremic shock (probably Gram Negative) 2 days		
7070 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 715X								Decubitus Ulcers, both buttocks 3 mons.		
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								Syndrome.		
1-Arteriosclerotic Cardiovascular Heart Disease, 2-Chronic Brain										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Feb. 9, 1968, to July 22, 1968, that (X) (we) lost saw the deceased alive on July 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Anthony J. Young, M.D.								7-22-68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
				SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7-25-1968		Western		Baltimore Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
B. Howard Strong				307 W. North Ave		DATE JUL 24 1968		f Charles Judge		

1900

1

1900

1900

1900

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

1900

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

UNITED STATES DEPARTMENT OF THE INTERIOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>09576</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6, Film G403 7/31/68 km</div> <div>09585</div>										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First Middle Last <b>WILLIAM AUGUSTUS GOVER</b>					Month Day Year <b>7 22 68</b>		4:15A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		5/29/99		68 69 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
HOWARD COUNTY, MARYLAND		U.S.A.				BALTIMORE COUNTY, MARYLAND Md.				
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ADM. HOSPITAL			FARMER		FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4803 Overton Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
SAMUEL H. GOVER			CLARA HOLLAND							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES WW I			219 16 09 59		CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL BLEEDING</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>PEPTIC ULCER OF DUODENUM</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>MASSIVE BRONCHOPNEUMONIA. SQUAMOUS CELL CARCINOMA METASTASES IN RIGHT UPPER LOBE</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <u>4/28/68</u> , 19 <u>68</u> , to <u>7/22/68</u> , 19 <u>68</u> , that (X) (we) lost saw the deceased alive on <u>7/22/68</u> , 19 <u>68</u> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<u>George C. McElpatrick</u>								7/22/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
GEORGE C. MC ELPATRICK, M. D.				VAH FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL				HYATTSTOWN, MARYLAND		HYATTSTOWN, MARYLAND				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
MC NABB FUNERAL HOME				JUL 25 1968		<u>Charles Judge</u>				
FREDERICK RD. & WADE AVE. CATONSVILLE, MD.										

2000

1. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

012002

10

ORDERED: JAN 10 1974

CHATELAIN, DENISE 1979 1024

[illegible]

UNIVERSITY OF CALIFORNIA, BERKELEY

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>ROBERT</b>  |  |  | Middle<br><b>O.</b>  |  |  | Last<br><b>GRAY</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>7</b> Day <b>1</b> Year <b>68</b> |  |  | 2b. HOUR<br><b>5:00AM</b>   |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>NEGRO</b>   |  |  | 5. DATE OF BIRTH<br><b>6/15/14</b>   |  |  | 6. AGE (In years last birthday)<br><b>54</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                               |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |  |  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PORTER</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>APARTMENTS</b>  |  |  |   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  | 13e. STREET AND NUMBER<br><b>1714 Normal Avenue</b>             |  |  |   |  |  |
| 14. FATHER'S NAME<br>First <b>OSCAR</b> Middle <b>R.</b> Last <b>GRAY</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>LULA</b> Middle <b>LEATHER</b> Last                                  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service)<br><b>WW II</b> |  |  |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>219 07 99 43</b>                 |  |  | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EMBOLISM</b><br><b>4441</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ACUTE THROMBOSIS AORTA ILIAC SEGMENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>466X</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b>  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>HYPERTENSION, DIABETES MELLITUS, UREMIA</b>   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>6/29/68</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ACUTE THROMBOSIS AORTO ILIAC SEGMENT</b>           |  |  | 20a. AUTOPSY?<br><b>NO</b> <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |   |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/22/68</b> , 19 <b>68</b> , to <b>7/1/68</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <b>7/1/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>George C. McElpatrick</i>  |  |  | DEGREE  |  |  | ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  | 22c. DATE SIGNED<br><b>7/1/68</b>   |  |  |   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GEORGE C. MC ELPATRICK, M. D.</b>  |  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>7-5-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |  |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS<br><b>MORTEN &amp; DYETTE FUNERAL HOME</b>  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUL - 2 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. J...</i>  |  |  |   |  |  |   |  |  |

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
OF THE  
UNITED STATES  
DEPARTMENT OF THE  
INTERIOR  
WASHINGTON, D. C.  
1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |                   |   |             |  |  |
|---|--|--|--|--|-------------------|---|-------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                   |   |             |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |                   |   |             |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle   | Last              | 2a. DATE OF DEATH   |             |  | 2b. HOUR                                     |
| SAMUEL  |  |  |  | Alexander  | GREEN, SR.        | Month 7 Day 19 Year 68  |             |  | 7:00aM                                       |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   | 6. AGE (In years lost birthday)   |             | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| Male  |  | Caucasian  |  | Feb. 1, 1886   |                   | 82 YRS.   |             | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED<br>WIDOWED  |                   | 9. COUNTY OF DEATH  |             | Md.  |  |
| Maryland  |  | USA  |  | <input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> DIVORCED |                   | Baltimore   |             |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) |                   | 12b. KIND OF BUSINESS OR INDUSTRY   |             |  |  |
| Towson  |  | GREATER BALTO. MED. CENTER   |  | Judge - Retired  |                   | Orphan's Court  |             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |             | 13e. STREET AND NUMBER   |  |
| Maryland  |  | Baltimore  |  | Towson   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |             | 204 E. Nappa Rd.   |  |
| 14. FATHER'S NAME   |  |  | First  | Middle   | Last              | 15. MOTHER'S MAIDEN NAME  |             |  | First Middle Last                            |
| Alexander   |  |  | Green  |  |                   | Elizabeth   |             |  | Chew   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT     |   | Address     |  |  |
| Yes, no, or (unknown)   |  |  | 219-20-8531A   |  | Mildred H. Green. |   | Towson, Md. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br><u>492 X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Severe pulmonary emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |                   |   |             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>5277 Cardiomegaly with permanent pacemaker</u>  |  |  |  |  |                   |   |             |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |             |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>68</u> , to <u>7/19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/19</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |                   |   |             |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |                   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |             | 22c. DATE SIGNED   |  |
| <u>Rudiger Breitenecker</u>   |  |  |  |  |                   |   |             | 7/19/68  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS   |  |                   |   |             |  |  |
| Rudiger Breitenecker, M. D.   |  |  | Greater Baltimore Medical Center   |  |                   |   |             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)   |             |  |  |
| Burial  |  | July 22, 1968  |  | Prospect Hill Cemetery   |                   | Towson, Md.   |             |  |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS  |  |                   | 25a. REC'D BY REGISTRAR   |             | 25b. REGISTRAR'S SIGNATURE   |  |
| John Burns Sons   |  |  | Towson   |  |                   | JUL 23 1968   |             | Charles J. J...  |  |



00000

OFFICE OF THE

00000

00000

00000

00000

00000

00000

00000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09579  |         | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                  | 09588   |   |
|--|---------|--|------------------|---|---|
| CERTIFICATE OF DEATH   |         |  |                  |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |         | First  | Middle           | Last  | 2a. DATE OF DEATH<br>Month Day Year                                       |
| Samuel   |         |  |                  | Greenfeld   | 7 26 1968   |
| 3. SEX   | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday)   |
| Male   | White   |  | 5-18-13          |   | 55 YRS.   |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 9. COUNTY OF DEATH  |   |
| BALTO. MD  |         | U.S.A.   |                  | BALTIMORE CO. Md.   |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |
| Randallstown   |         | Balto. Co. Hospital  |                  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |                  | 13c. STREET AND NUMBER  |   |
| Maryland   |         | BALTO.   |                  | 8510 GREENS LAKE  |   |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN-NAME   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)      |   |
| Jacob  |         | Greenfeld  |                  | No  |   |
| 16b. SOCIAL SECURITY NO.   |         | 17. INFORMANT  |                  | Address   |   |
| 219-05-3897  |         | Police Dept.   |                  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c) 4 yrs<br>420.1 Diabetes Mellitus |         |  |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4'<br>4 yrs<br>over 4 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>420.1 Diabetes Mellitus  |         |  |                  |   |   |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)         |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to 7-26-1968, that (I) (we) last saw the deceased alive on June 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |         |  |                  |   |   |
| 22b. SIGNATURE<br>G-M-Ramapuram M.D.   |         |  |                  | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (Type)   |         |  |                  | 22e. ADDRESS  |   |
| G-M-Ramapuram M.D.   |         |  |                  | 3502 Croydon Rd, Balt, Md 21211   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |   |
| Burial   |         | July 28-1968   |                  | Ahavas Shalom   |   |
| 24. FUNERAL DIRECTOR   |         | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE  |   |
| Sylvan S. Lewis  |         | JUL 31 1968  |                  | Charles Judge   |   |

00288

00288

Gravel 7 20 100 100  
5-18-13

White  
H. 2. H.

White

Bole Co. Hospital

Bole Co. Hospital

Bole Co. Hospital

*[Faint, mostly illegible handwritten notes and text covering the middle section of the page.]*

*[Faint, mostly illegible handwritten notes and text at the bottom of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RELEASED BY MED EXAM. AS NON MEDICAL

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |                   |  |   |   |                                      |   |         |
|---|--|---|---|---|-------------------|--|---|---|--------------------------------------|---|---------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |                   |  |   |   |                                      |   |         |
| CERTIFICATE OF DEATH  |  |   |   |   |                   |  |   |   |                                      |   |         |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First   | Middle  | Last              | 2a. DATE OF DEATH<br>Month   |   | Day   | Year                                 | 2b. HOUR  |         |
| PAUL JOSEPH GUTOWSKI  |  |   |   |   |                   | DOA  |   | 7   | 25                                   | 1:10 P  |         |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |                   | 6. AGE (In years<br>last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS   |                                      | IF UNDER 24 HRS.<br>HOURS                       |         |
| MALE  |  | CAUCASIAN   |   | Nov. 28, 1960   |                   | 7  |   |   |                                      |   |         |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH   |   |   |                                      |   |         |
| Maryland  |  | U. S. A.  |   |   |                   | BALTIMORE  |   |   |                                      |   |         |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |         |
| BALTIMORE   |  |   | Greater Balto Medical Center  |   |                   | Student Battle Monument School   |   |   |                                      |   |         |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE  |  |   | 13b. CITY   |   | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER               |   |         |
| Maryland  |  |   | Baltimore   |   | Dundalk           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 1946 Stanhope Road                   |   |         |
| 14. FATHER'S NAME   |  |   | First   | Middle  | Last              | 15. MOTHER'S MAIDEN NAME   |   |   | First                                | Middle  | Last    |
| Ernest  |  |   |   |   | Gutowski          | Dolores  |   |   |                                      |   | Pensker |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |   | 16b. SOCIAL SECURITY NO.  |   |                   | 17. INFORMANT (Father)   |   |   | Address                              |   |         |
| No  |  |   | None  |   |                   | Mr. Ernest Gutowski, 1946 Stanhope Rd.   |   |   | Dundalk, Md.                         |   |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TERMINAL METASTATIC WILM'S TUMOR</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 1/2 yr</u> |  |   |   |   |                   |  |   |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>180X</u>  |  |   |   |   |                   |  |   |   |                                      |   |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                      |   |         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                   |  |   |   |                                      |   |         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION   |                   | Street or R.F.D. No.   |   | City or Town  |                                      | County  | State   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>68</u> to <u>FEB</u> , 19 <u>63</u> , that (I) (we) last saw the deceased alive on <u>JUNE</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                   |  |   |   |                                      |   |         |
| 22b. SIGNATURE<br><u>Alan M. Davick, M.D.</u>   |  |   |   |   |                   | 22c. DATE SIGNED<br><u>7/25/68</u>   |   | 22d. PHYSICIAN'S<br>NAME (Type)   |                                      |   |         |
| ALAN M. DAVICK, M.D.  |  |   |   |   |                   | 22e. ADDRESS<br>6701 NORTH CHARLES ST BALT, MD   |   |   |                                      |   |         |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION (City or Town) (County) (State)  |   |   |                                      |   |         |
| Burial  |  | 7/29/68   |   | St. Stanislaus Cemetery   |                   | Baltimore, Maryland  |   |   |                                      |   |         |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.   |  |   |   |   |                   | 25a. REC'D BY REGISTRAR<br>DATE  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                      |                                      |   |         |
|   |  |   |   |   |                   | JUL 29 1968  |   |   |                                      |   |         |

602

254

2 9 2

2000

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

7-11-11

17

© 2000 Blackwell Science Ltd *Journal of Internal Medicine* 247: 399–406

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09582

09590

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARGARET GUY</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>JULY</b> Day <b>15</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>1:15P</b> M   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br><b>JULY 29, 1892</b>  |  | 6. AGE (in years last birthday)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MO.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ESSEX</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>707 EASTERN AVE</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MO.</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>ESSEX</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>LEONARD</b> Middle <b>HESSMAUER</b> Last  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ELIZABETH</b> Middle <b>EBBY</b> Last <b>HAUSEN</b>               |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-3729</b>   |   | 17. INFORMANT<br>Address <b>RUSSELL GUY 169 FORGE RD.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.<br><b>SUDDEN DEATH</b><br><b>6 YRS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4221</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 1, 1953</b> , to <b>JULY 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>MAY 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Joseph Miceli MD</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7/16/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOSEPH MICELI, MD</b>  |  |  |   | 22e. ADDRESS<br><b>108 S TAYLOR AVE</b>   |  | <b>ESSEX, MD 21221</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>7/18/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                           |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |  |  |   | ADDRESS<br><b>300 MACE</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 18 1968</b>   |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

00000

1000

M

10

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7/68

|   |  |   |        |   |   |   |                                |   |                                |  |
|---|--|---|--------|---|---|---|--------------------------------|---|--------------------------------|--|
| 09582   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |        | 09591   |   |   |                                |   |                                |  |
| CERTIFICATE OF DEATH  |  |   |        |   |   |   |                                |   |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Elizabeth  | Middle | Last<br>Hacker (Hahn)   | 2a. DATE OF DEATH<br>Month<br>July Day 11 Year 1968 | 2b. HOUR<br>3:45 M  |                                |   |                                |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |        | 5. DATE OF BIRTH<br>June 23, 1878   |   | 6. AGE (In years<br>last birthday)<br>90 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Germany   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |                                |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Edgemere   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>7423 North Point Rd. |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                                |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |        | 13c. CITY OR TOWN<br>Edgemere   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET AND NUMBER<br>7423 North Point Road |                                |  |
| 14. FATHER'S NAME<br>First<br>Anton   |  | Middle<br>Witkofsky   |        | Last<br>Lotta   |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Kolpac   |                                |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>None  |        | 17. INFORMANT (Son)<br>Mr. Anton Hahn, 7423 North Point Rd.   |   |   | Address: Edgemere, Md.         |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |        |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 yrs<br>2 yrs.                              |                                |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200  |  |   |        |   |   |   |                                |   |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                                |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                                |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>OFFICE BUILDING, ETC.)                         |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |                                |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1965</u> to <u>July 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |        |   |   |   |                                |   |                                |  |
| 22b. SIGNATURE<br><u>Roger G. Windsor MD</u>  |  | DEGREE  |        | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br>7/12/68   |                                |   |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Roger G. Windsor  |  | 22e. ADDRESS<br>520 "D" St. Sparrows Point, Md. 21219   |        |   |   |   |                                |   |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>7/15/68  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Park  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |                                |   |                                |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.   |  |   |        | 25a. REC'D BY REGISTRAR<br>DATE JUL 15 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                |   |                                |  |

11700

11700

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

11700

June 22, 1908

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

JUL 1 1908

U. S. DEPT. OF AGRICULTURE

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
09583  
09592  
CERTIFICATE OF DEATH

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>                |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Providence 21204</i>   |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Providence 21204</i>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>1533 Providence Road</i>   |                                  | d. STREET ADDRESS<br><i>1533 Providence Road</i>  |   |
| 3. NAME OF DECEASED (Type or print)<br><i>Minna Barbara Hacker</i>  |                                  | 4. DATE OF DEATH<br>Month <i>July</i> Day <i>22</i> Year <i>1968</i>  |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>April 22, 1896</i> |
| 9. AGE (In years last birthday)<br><i>72</i> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Germany</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 13. FATHER'S NAME<br><i>Ferdinand Mueller</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Anna Knoefler</i>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>None</i>  |   |
| 17. INFORMANT<br><i>Family records</i>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARCINOMA OF STOMACH</i><br><i>151.9</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>151X</i> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>10 mos</i>   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (his hospital) attended the deceased from <i>Sept 1, 1967</i> , to <i>July 22, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 10, 1968</i> , and that death occurred at <i>1:30</i> P.M. from the causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><i>William A. Piusbury</i>  |                                  | 22b. DATE SIGNED<br><i>7-23-68</i>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>William A. Piusbury</i>  |                                  | 22d. ADDRESS<br><i>Timonium, Md.</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Cremation</i>   |                                  | 23b. DATE THEREOF<br><i>July 24, 1968</i>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenpoint Cemetery</i>  |                                  | 23d. LOCATION (City, town or county) (State)<br><i>Baltimore, Maryland</i>  |   |
| 24. FUNERAL DIRECTOR<br><i>John Burns' Sons, Towson, Maryland</i>   |                                  | 25a. REC'D BY REGISTRAR<br><i>JUL 29 1968</i>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |                                  |   |   |

Continued July 24, 1963 (Continued)  
John Lewis, Mrs. Tolson, Mr. Tolson, Mr. DeLoach, Mr. Mohr, Mr. Bishop, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. Felt, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

Continued July 24, 1963 (Continued)  
Mr. Tolson, Mr. DeLoach, Mr. Mohr, Mr. Bishop, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. Felt, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

Continued July 24, 1963 (Continued)  
Mr. Tolson, Mr. DeLoach, Mr. Mohr, Mr. Bishop, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. Felt, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

# FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09593

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                  |   |  |   |  |  |  |   |  |  |  |
|---|------------------|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                  | First<br>John   |  | Middle<br>Robert  |  | Last<br>Hagenrater   |  | 20. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month Day Year<br>July 21 1968 |  | 2b. HOUR<br>10 P.M.  |  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>Nov. 28, 1914   |  | 6. AGE (In years last birthday)<br>53 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>July 21 1968 |  |
| 70. BIRTHPLACE (State or foreign country)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Balto. Co. Gen. Hosp. |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Painter |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Painter  |  |  |  |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |                  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Randallstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET AND NUMBER<br>9015 Marcella Ave.  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>John William Hagenrater   |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Emma Sudman  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>yes  |                  | (If yes give war and dates of service)<br>W.W. II   |  | 16b. SOCIAL SECURITY NO.<br>217-01-6061   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Arlie Hagenrater, Randallstown, Md.                               |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anaphylactic Reaction (Bee sting)</u><br>905X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>9270  |                  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>none  |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOURS MIN.<br>1 P.M. July 21, 1968                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>stung by bee   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>cellar at home        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>9013 Marcella Ave., Randallstown, Balto., Md.   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |   |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>D. D. Caples  |                  | EXAMINER'S NAME (Type)<br>D. D. Caples, M.D.  |  | 6 Hanover Rd.   |  | BALTIMORE, Md.   |  | 22b. DATE SIGNED<br>7-21-68   |  |  |  |
| 230. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>7-24-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olive Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Randallstown Md.                                  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Harry W. Haight   |                  |   |  | ADDRESS<br>Lykesville, Md.  |  | 25a. REC'D BY REGISTRAR<br>DATE JUL 26 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

22720

100

2000

100



VR A15 (4)  
20M 1/65

BP

## MEDICAL CERTIFICATION

[illegible]

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>                   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Lutherville</u>   |  | c. LENGTH OF STAY IN 1b<br><u>18 Wendslow Road</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>18 Wendslow Road</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Robert</u> Middle <u>F.</u> Last <u>Harman</u>   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>5</u> Year <u>1968</u>   |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>Dec. 23, 1901</u>  |  |
| 9. AGE (In years last birthday)<br><u>66</u> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Mechanic</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Golf Course</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>John W. Harman</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ada Parks</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |  | 16. SOCIAL SECURITY NO.<br><u>212-10-7439 A</u>   |  |
| 17. INFORMANT<br><u>Family records</u>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>4109<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>(c) <u>  </u><br>DUE TO<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>4201 |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>62</u> , to <u>July</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 2nd</u> 19 <u>68</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><u>M. X. Quinn</u>   |  | 22b. DATE SIGNED<br><u>7-9-68</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>M. KEVIN QUINN MD</u>   |  | 22d. ADDRESS<br><u>1927 YORK RD, TIMONIU, MD</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>7/9/68</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Grace Methodist Church</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Cockeysville Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns Sons</u>   |  | 25a. REC'D BY REGISTRAR<br><u>JUL 15 1968</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |  |

1958

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

10/10/58

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print)  |  | First<br>Charles   |  | Middle<br>O.  |  | Last<br>Harting, Sr.  |  | 2a. DATE OF DEATH<br>7 Month 9 Day 68 Year        |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>4-25-1908   |  | 6. AGE (In years<br>last birthday)<br>60 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Lansdowne   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>2917 Hammonds Ferry Rd. |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Building Supplies   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Self Employed   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. CITY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Lansdowne  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2917 Hammonds Ferry Rd. |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>William A. Harting  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Anna (unknown)  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>No.  |  | 16b. SOCIAL SECURITY NO.<br>212-09-9863  |  | 17. INFORMANT Address<br>Catherine E. Harting 2917 Hammonds Ferry Rd.   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A.C.U.D. &amp; Aneurysm</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diverticulitis</u> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 years</u><br><u>2 months</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4331</u>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.)                            |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Paul Schuber</u>  |  | DEGREE   |  | ATTENDING<br>PHYS.  |  | <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS.    |  | 22c. DATE SIGNED<br>7/11/68                       |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><u>Paul Schmold</u>   |  | 22e. ADDRESS<br><u>2301 Annapolis Rd</u>   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>7-12-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION (City or Town)<br>Frederick Ave. Balto.   |  | (County)  |  | (State)<br>Md.   |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Avenue 29  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE JUL 15 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |  |  |

48364

DEPARTMENT OF HEALTH

48364

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The following" and "is" are faintly visible.]*

*[Faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side.]*

*[Faint, mostly illegible text at the very bottom of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV. 4-1-68

|  |  |  |   |   |                           |   |  |
|--|--|--|---|---|---------------------------|---|--|
| 09587  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |   |   |                           | 09596   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |                           |   |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Sister Mary Oscar Hoffman</i>   |  |  | 2a. DATE OF DEATH<br>Month <i>7</i> Day <i>7</i> Year <i>1968</i> |   | 2b. HOUR<br><i>1 P.M.</i> |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br><i>7-12-1875</i>  |                           | 6. AGE (In years last birthday)<br><i>92</i> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Germany</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Glen Arm Md.</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Glen Arm, Md.</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Teacher</i>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>EDUCATION</i>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>GLEN ARM</i>  |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><i>GLEN ARM ROAD</i>   |  | 14. FATHER'S NAME<br>First <i>Matthias</i> Middle <i>Hoffman</i> Last <i>Hoffman</i>                 |   | 15. MOTHER'S MAIDEN NAME<br>First <i>Gertrude</i> Middle <i>Herman</i> Last <i>Herman</i>   |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>218-54-1327</i>   |   | 17. INFORMANT<br><i>Sc. M. Kathleen</i>   |                           | Address<br><i>same</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4369 Congestive heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA Cerebrovascular accident</i> |  |  |   |   |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>331X</i>   |  |  |   |   |                           |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                           |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                           |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-1-1966</i> , to <i>6-27-1968</i> , that (I) (we) last saw the deceased alive on <i>6-27-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                           |   |  |
| 22b. SIGNATURE<br><i>Henry L. McCable</i>  |  | DEGREE<br><i>MD</i>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |                           | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>HENRY L. MC CORKLE MD</i>   |  | 22e. ADDRESS<br><i>JARRETTVILLE PIKE, PHOENIX MD</i>   |   |   |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>7-9-68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SISTERS CEMETERY</i>   |                           | 23d. LOCATION (City or Town) (County) (State)<br><i>GLEN ARM, BALTIMORE, MD</i>                 |  |
| 24. FUNERAL DIRECTOR<br><i>RAYMOND J. CURRAN</i>   |  | ADDRESS<br><i>817 SCARLETT DR TOWSON, MD. 21204</i>  |   | 25a. REC'D BY REGISTRAR<br><i>JUL 10 1968</i>   |                           | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

00000

00000

00000

00000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If the deceased was removed from the hospital, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1

09588

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09597

# CERTIFICATE OF DEATH

|   |  |   |  |   |   |   |  |   |         |  |
|---|--|---|--|---|---|---|--|---|---------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>KATIE WILSON HOLLAND</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>JULY</b> Day <b>4</b> Year <b>1968</b>         |   |   | 2b. HOUR<br><b>1:05 PM</b>  |  |   |         |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>8-21-1894</b>  |   | 6. AGE (In years last birthday)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |         |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>  |  |   |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Wilson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hosp.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4607 MARLAN STREET</b>             |         |  |
| 14. FATHER'S NAME<br>First <b>W.</b> Middle <b>F.</b> Last <b>WILSON</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>ALICE</b> Middle <b>DERFLINGER</b> Last |   |   |   |  |   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-52-8726</b>                               |   | 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>  |   |  |   | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, mild</b><br><b>518x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Emphysema, chronic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bronchiectasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>526x</b>  |  |   |  |   |   |   |  |   |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |         |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |   |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-6-</b> , 19 <b>68</b> , to <b>7-4-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-4-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |   |         |  |
| 22b. SIGNATURE<br><b>W. Newcomer</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |         |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |   |  |   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>July 8, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Hill</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland P. Dep. Md.</b>                    |  |   |         |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur Vetter</b>  |  | 24a. ADDRESS<br><b>254 Laurel St.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL - 8 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |         |  |

02530

02530

WILLIAM HENNING

2-8-1944

RAISING COUNTY

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

WILLIAM HENNING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item#5, Film#G402 7/9/68 vmp

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

09589

09598

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>RALPH F. HOWELL</b>   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>JULY 1 68</b>           |  | 2b. HOUR<br><b>1 A M</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>                        | 5. DATE OF BIRTH<br><b>9/17/68 1895</b>   |   | 6. AGE (In years last birthday)<br><b>72</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>N.Y.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTO.</b>                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>MIDDLE RIVER</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>28 KERRIA LANE</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SELF</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>MIDDLE RIVER</b>                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        | 13e. STREET AND NUMBER<br><b>28 KERRIA LANE</b>                  |
| 14. FATHER'S NAME First Middle Last<br><b>FREDERICK HOWELL</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>BERTHA SMITH</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>UNKNOWN</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-5183</b>  |   | 17. INFORMANT Address<br><b>ALICE HOWELL ABOVE</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of kidney</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 YRS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>180X</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 25, 1963</b> , to <b>JULY 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>JUNE 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Josepha Miceli MD</b>  |  |   |   | 22c. DATE SIGNED<br><b>7/1/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOSEPHA MICELI MD</b>  |  |   |   | 22e. ADDRESS<br><b>108 S TAYLOR AVE, ESSEX, BALTO. MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>7/3/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OREMS METH. CEM.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |  | ADDRESS<br><b>300 MACE</b>  |   | 25a. REC'D BY REGISTRAR<br><b>AUL - 5 1968</b>   |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

33308

11223

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |   |   |  |   |   |   |   |
|--|---|---|--|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print)  |   | First   | Middle   | Last  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year   |   | 2b. HOUR  |
| CHARLES W. B. HUGHES   |   |   |  |   | July 28 19 68   |   | M   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (In years<br>last birthday)   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year    | 2d. HOUR  |
| Male   | Caucasian   | 17 Mar 1889   | 79 YRS.  |   |   | 19  | M   |
| 7a. BIRTHPLACE (State or foreign<br>country)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |   |   |
| Md.  | U.S.A.  |   |  | Baltimore   |   | Md.   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |
| Colgate  | 705 S. 50th St.   |   | carpenter  |   |   |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       | 13e. STREET AND NUMBER  |   |   |   |
| Md.  | Balto.,   | Colgate   |  | 705 S 50th St.  |   |   |   |
| 14. FATHER'S NAME  |   | First   | Middle   | Last  | 15. MOTHER'S MAIDEN NAME  |   |   |
| Elisha Hughes  |   |   |  |   | Arabella Hoffman  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |   | ADDRESS                                       |   |
|  |   |   |  | Mrs. Dorothy H. Simms, 705 S 50th St.   |   | 21224   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1992   |   |   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town                                  | County State                                    |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |  |   |   |   |   |
| ACTUAL<br>SIGNATURE  |   | Theoc Patterson M.D.  |  |   | 22b. DATE SIGNED  |   |   |
| EXAMINER'S<br>NAME (Type)  |   | T.C. Patterson, MD 105 Main   |  |   | 7/30/68   |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State) |   |
| burial   |   | 7-31-68   |  | Oak Lawn Cemetery   |   | Baltimore County, Md.                         |   |
| 24. FUNERAL DIRECTOR   |   |   |  | ADDRESS   |   | 25a. REGD. BY REGISTRAR                       |   |
| Ulrich Funeral Home, Dundalk, Md.  |   |   |  |   |   | 25b. REGISTRAR'S SIGNATURE                    |   |
|  |   |   |  | DATE  |   | AUG 2 1968                                    |   |

FOR STATE  
DEPARTMENT

1957

ADMINISTRATIVE DEPARTMENT OF DEFENSE

1957

1957

1957

1957

1957

1957

1957

1957

1957



1957

1957

1957

1957



09592

## CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>T. Oliver Hughes</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>2:00 PM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>2-15-1890</b>  |  | 6. AGE (In years lost birthday)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Shangri-La, N.H.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Self Employed Lumber Company</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Balto,</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>4017 Chatham Road</b>   |  | 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Hughes</b> Last <b>Hughes</b>                       |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Emma</b> Middle <b>Clemens</b> Last <b>Clemens</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-7711</b>  |  | 17. INFORMANT<br>Address <b>Daniel Conroy-4017 Chatham Road</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>332x Urinary tract infection</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/6/</b> 19 <b>68</b> , to <b>7/8/</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/6/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Marvin Goldstein, M.D.</b> DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br><b>7/8/68</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MARVIN GOLDSTEIN</b>  |  |   |  | 22e. ADDRESS<br><b>6001 PARK HEIGHTS AVE. BALTO, MD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-11-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL - 9 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

only 100

100

100

100

100

100

only 100

100

100

only 100

100

100

only 100

100

100

only 100

100

only 100

only 100

only 100

100

100

100

only 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |         |  |                  |                                    |  |   |   |  |  |  |
|--|--|---------|--|------------------|------------------------------------|--|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |         |  |                  |                                    |  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |         | First  |                  | Middle                             |  | Last  |   | 2a. DATE OF DEATH<br>Month Day Year                                  |  |  |
| GERTRUDE   |  |         | PUTTS  |                  | HUNT                               |  |   |   | July 28 1968   |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |                                    |  | 6. AGE (In years lost birthday)   |   | 7b. HOUR   |  |  |
| FEMALE   |  | CAUC    |  | Feb 12, 1894     |                                    |  | 74 YRS.   |   | 6 a M  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |  |
| Virginia   |  |         | Winchester   |                  |                                    |  |   | Baltimore   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| BALTIMORE  |  |         | GBMC 6701 N. Charles St  |                  |                                    | Dumpling   |   |   | Own home   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         | 13b. COUNTY  |                  |                                    | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET AND NUMBER                       |  |
| Md.  |  |         | Baltim   |                  |                                    | Pikesville   |   |   |  | 115 Old Court Road                           |  |
| 14. FATHER'S NAME  |  |         | First  |                  | Middle                             |  | Last  |   | 15. MOTHER'S MAIDEN NAME   |  |  |
| George   |  |         | Kremer   |                  |                                    |  |   |   | Lundberg   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |         | 16b. SOCIAL SECURITY NO.   |                  |                                    | 17. INFORMANT  |   |   | Address  |  |  |
|  |  |         | 219-22-4460  |                  |                                    | Mrs. Michael Thomas  |   |   | 509 Pleasant Hill Rd   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  |                                    |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |         |  |                  |                                    |  |   |   |  |  |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest   |  |         |  |                  |                                    |  |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |                                    |  |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |         |  |                  |                                    |  |   |   |  |  |  |
| (b) Generalized Sarcomatous Spread   |  |         |  |                  |                                    |  |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |                                    |  |   |   |  |  |  |
| (c) Reticulum Sarcoma of Pelvis  |  |         |  |                  |                                    |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |  |                  |                                    |  |   |   |  |  |  |
| 200.0  |  |         |  |                  |                                    |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |                                    |  | 20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |         |  |                  |                                    |  |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY  |                  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |  |
|  |  |         | HOUR A.M. Month Day Year P.M. 19   |                  |                                    |  |   |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |                                    | 21f. LOCATION Street or R.F.O. No. City or Town County State   |   |   |  |  |  |
|  |  |         |  |                  |                                    |  |   |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from June 24, 1968, to July 28, 1968, that (we) last saw the deceased alive on July 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |         |  |                  |                                    |  |   |   |  |  |  |
| 22b. SIGNATURE   |  |         |  |                  |                                    | DEGREE   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
| Carlos MacFarlane, M. D.   |  |         |  |                  |                                    |  |   |   |  | 7-28-68                                      |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |         |  |                  |                                    | 22e. ADDRESS   |   |   |  |  |  |
| 5611 Lothian Road, Baltimore, Md.  |  |         |  |                  |                                    |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| Buried   |  |         | July 31, 1968  |                  | Baltimore National Cemetery        |  |   | Baltimore   |  | Md.  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  |                                    | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| David Funeral Home   |  |         |  |                  |                                    | Pikesville   |   | JUL 31 1968   |  | Charles Judge                                |  |

10000

10000

10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

10000 10000 10000 10000 10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09593

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09602

CERTIFICATE OF DEATH

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HILDA</b>   |  |  | First Middle Last<br><b>A. HUNT</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>July 3 1968</b>   |  |  | 2b. HOUR<br><b>6:50p</b>  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br><b>June 8, 1906</b>   |  |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.                                 |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Seamstress</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Baltimore</b>   |  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>2919 Fleetwood Ave., 21214</b>  |  |  | 14. FATHER'S NAME First Middle Last<br><b>John A. Franke, Jr.</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Barbara Peska</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Yes, no, or unknown</b>   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><b>Walber E. Hunt 2919 Fleetwood Ave.</b>  |  |  | Address   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma, lungs-with cerebral metastasis</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1638</b>  |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1968</b> , to <b>July 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Beatriz Dizon M.D.</b> DEGREE   |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>7/3/68</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Beatriz Dizon, M.D.</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>7/8/68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>             |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, inc. 5305 Harford Rd.</b>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL - 5 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                |  |  |



Handwritten signature or mark at the bottom left.

RECEIVED IN 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>HAZEL MAY JACKSON</b>  |  |   |  |   | 2a. DATE OF DEATH<br>Month 7 Day 19 Year 68   |   |  | 2b. HOUR<br>30 P M                         |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br><b>2/12/10</b>  |   | 6. AGE (In years last birthday)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>W. VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GBMC</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>SEVERN</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>BOX 1 214</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>JAMES GODWIN</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ANNA SHAFER</b>                            |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>236-20-0155</b>  |  | 17. INFORMANT Address<br><b>PATIENT'S CHART</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF CERVIX WITH METASTASES</b><br><b>180x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>171x</b>   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>7/18/68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INTESTINAL OBSTRUCTION</b>           |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Edwardo M. Cantilang</b>  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>7/19/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EDUARDO M. CANTILANG</b>  |  |   |  | 22e. ADDRESS<br><b>6701 N CHARLES ST, BALT, MD</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMQVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jul. 22, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie A.A. Md.</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Barclay E. Hopping</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 23 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

10329

4

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

09595

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09604

|  |         |  |  |   |  |   |  |   |  |                               |  |  |  |
|--|---------|--|--|---|--|---|--|---|--|-------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH   |  |                               |  | 2b. HOUR                                     |  |
| ROBERT   |         |  |  | ALAN  |  | JONES   |  | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year<br><input checked="" type="checkbox"/> July 20, 19 68 |  |                               |  | 9:30 M                                       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD      |  | 2d. HOUR                                     |  |
| Male   | White   | 6/11/49  |  | 25 1/2 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.  |  | Month July Day 20, Year 19 68 |  | 9:30 M                                       |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH  |  |                               |  |  |  |
| MD   |         | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore   |  |                               |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                               |  |  |  |
| Essex  |         | 1517 Shore Road  |  | BARBER  |  |   |  |   |  |                               |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |  |                               |  |  |  |
| MD   |         | BALTA  |  | ESSEX   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | APT. B <sup>2</sup> BEACH DR  |  |                               |  |  |  |
| 14. FATHER'S NAME  |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First                         |  | Middle                                       |  |
| BOUDGER T. JONES   |         |  |  |   |  |   |  | MARGARE JOHNSON   |  |                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                               |  |  |  |
| UNK  |         | 217-56-0307  |  | SUSAN JONES   |  | ABOVE   |  |   |  |                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |   |  |   |  |                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| IMMEDIATE CAUSE (a) Drowning   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| (b)  |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| (c)  |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| 9298   |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |   |  | 20. AUTOPSY?  |  |                               |  |  |  |
|  |         |  |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                               |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |  |  | 21b. TIME OF INJURY Month, Day, Year  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |                               |  |  |  |
|  |         |  |  | ? HOUR A.M. ? P.M. ? 19 ?   |  |   |  | Subject was found approximately 100 yd. of pier.  |  |                               |  |  |  |
| 21d. INJURY OCCURRED   |         |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)            |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |                               |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |  | Pier  |  |   |  | 1517 Shore Rd. Essex Baltimore M.D.   |  |                               |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| ACTUAL SIGNATURE   |         |  |  | CHIEF MEDICAL EXAMINER  |  |   |  | 22b. DATE SIGNED  |  |                               |  |  |  |
| Edward F. Wilson, M.D.   |         |  |  | M.D.  |  |   |  | July 21, 1968   |  |                               |  |  |  |
| EXAMINER'S NAME (Type)   |         |  |  | DEPUTY MEDICAL EXAMINER   |  |   |  | ADDRESS (Street, city, town, or county)   |  |                               |  |  |  |
|  |         |  |  |   |  |   |  |   |  |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                       |  |   |  |                               |  |  |  |
| BURIAL   |         | 7/24/68  |  | OAK LAWN  |  | BALTO. MD.  |  |   |  |                               |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE    |  |  |  |
| J.G. CONNELLY SONS   |         |  |  | 300 MACE  |  |   |  | DATE JUL 24 1968  |  | Charles J. J...               |  |  |  |

202

830 20 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Gregory</b>  |  |  | First Middle Lost<br><b>- KARSACK</b>                                      |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>7 11 68</b>   |  | 2b. HOUR<br><b>10:08 PM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>3/12/53</b>  |   | 6. AGE (In years last birthday)<br><b>15</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dependent</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Rosewood State Hospital St. / Agnes Hospital (all of)</b> |  |
| 14. FATHER'S NAME<br>First Middle Lost<br><b>William Travers</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><b>Katherine Kernicky</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b><br>(If yes give war or dates of service) <b>--</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>                                    |   | 17. INFORMANT<br>Address<br><b>Rosewood Records, Owings Mills, Maryland</b> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Orthostatic Bronchial Pneumonia</b><br><b>742X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Interval Hydrocephalus, Congenital</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>15 yrs</b> |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (I)<br><b>752X institutionalized 15 yrs, Severe Mental Retardation</b>   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> , 19 <b>53</b> , to <b>7/11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard A. Jones</b>  |  | 22c. DATE SIGNED<br><b>7/16/68</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Richard A. Jones, M.D.</b>   |   |   |  |  |  |
| 22e. ADDRESS<br><b>Rosewood St. Hosp., Owings Mills, Md.</b>   |  |  |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>July 17, 68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosewood Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Owings Mills, Md.</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. F. Elige &amp; Sons</b>  |  |  |  | ADDRESS<br><b>Reisterstown, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 22 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                     |  |

22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |   |   |  | 09606                                      |  |
|--|--|--|--|---|--|--|---|---|--|--|--|
| Item #5,6, Film G402 7/15/68 km  |  |  |  |   |  |  |   |   |  | CERTIFICATE OF DEATH                       |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>CLARA Louise Kelley   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>JULY 2, 1968  |   |   | 2b. HOUR<br>8:00 A.M.                      |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White                         |  | 5. DATE OF BIRTH<br>May 24, 1889  |  | 6. AGE (In years last birthday)<br>79 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A. |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore  |   |   | Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>16 Millstone Rd. |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Randallstown                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>10 Millstone Rd. |  |  |
| 14. FATHER'S NAME First Middle Last<br>Arnold - Gries  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>MARY Ann Triplett                                  |   |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No -   |  |  | 16b. SOCIAL SECURITY NO.<br>-  |   | 17. INFORMANT Address<br>MRS. Wilson Berry Randallstown, Md. |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>1519 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cancer of stomach</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |  |  |  |   |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>151X  |  |  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                       |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                      |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                     |   |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County State                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966, to 7/3/68, that (I) (we) last saw the deceased alive on 7/1/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Wm E. Martin, M.D.   |  |  |  |   |  | DEGREE<br>M.D.   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/3/68                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Wm E. Martin   |  |  |  |   |  | 22e. ADDRESS<br>Randallstown Md  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>7-5-68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Wards Chapel           |  | 23d. LOCATION (City or Town) (County) (State)<br>Randallstown Md.                               |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Harry W Haight   |  |  |  |   |  | ADDRESS<br>Sykesville, Md.   |   | 25a. REC'D BY REGISTRAR<br>DATE UL - 8 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Juge |  |



*Handwritten signature or initials.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |   |   |   |  |   |  |
|--|--|--|---|---|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM HENRY KIMMERLE</b>  |  |  |   |   | 2a. DATE OF DEATH<br><b>July</b> Month <b>12</b> Year <b>1968</b>   |   | 2b. HOUR<br><b>3:40PM</b>   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Jan. 1, 1900</b>   |   | 6. AGE (In years last birthday)<br><b>68</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital and street address)<br><b>VA Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Laborer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Park Board</b>           |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>513 S. Ann Street</b>            |  |
| 14. FATHER'S NAME First Middle Last<br><b>Henry Kimmerle</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Theresa</b>                                      |   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, na, and unknown) <b>Yes WW II</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216 07 51 41</b>   |   | 17. INFORMANT Address<br><b>Clinical Records, VA Hospital, Ft Howard, Md.</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PROSTATE WITH METASTASES</b><br><b>185X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>177X</b>  |  |  |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15</b> , 19 <b>68</b> , to <b>July 12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/12/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |   |   |   |   |   |  |   |  |
| 22b. SIGNATURE <b>Jorge A. Fabara</b>  |  |  |   |   | DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/12/68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JORGE A. FABARA, M.D.</b>   |  |  |   |   | 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, <b>Burial</b> (City)   |  | 23b. DATE<br><b>7-16-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                               |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>ZEILER &amp; LILLY INC.</b>   |  |  |   | ADDRESS<br><b>403 S. Wolfe Street Baltimore, Maryland</b>   |   | 25. REC'D BY REGISTRAR<br><b>JUL 15 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jorge A. Fabara</b>             |   |  |

222

5320

УДК 62-50

1325

21

1075-71-0000

12

5017

• • •

•

1992

Andersson, 1994) and (3) the use of a single, non-validated questionnaire to assess the prevalence of the disorder.

Author

1997

STON 11 23

4423

•

6248 • J. Neurosci., September 24, 2008 • 28(39):6242–6251

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND DEPARTMENT OF HEALTH   |  |  |   |  |  |  |  |  |  |  |                             |
|---|--|--|---|--|--|--|--|--|--|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |  |  |  |  |  |                             |
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  |  |                             |
| 1. DECEASED-NAME (Type or print) <b>JESSIE</b>  |  |  |   | First Middle Last <b>K. KIRKPATRICK</b>  |  |  |  | 2a. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1968</b> |  |  | 2b. HOUR <b>7:39 PM</b>     |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH <b>August 5, 1891</b>   |  |  | 6. AGE (In years last birthday) <b>76</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS                        |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |  |  |  |                             |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Glass blower's helper</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Glass</b>     |  |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN <b>Edgemere</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>7240 River Drive Rd.</b> |  |                             |
| 14. FATHER'S NAME First Middle Last <b>Frederick Keller</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Allie Schiefer</b>   |  |  |  |  |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO. <b>235-36-5409</b>   |  | 17. INFORMANT Address <b>Mrs. Evon K. Long Rt. 2 Fallston Md. Parkview Rd. Box A69</b> |  |  |  |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |  |  |  |  |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>   |  |  |   |  |  |  |  |  |  |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY: HOUR A.M. Month Day Year P.M. <b>19</b>                 |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |  |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |                             |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>July 19</b> , 19 <b>68</b> , to <b>July 22</b> , 19 <b>68</b> , that <del>it</del> (we) last saw the deceased alive on <b>July 22</b> , 19 <b>68</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |   |  |  |  |  |  |  |  |                             |
| 22b. SIGNATURE <b>Lilia C. Baldonado</b> -DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |   |  |  | 22c. DATE SIGNED <b>7/22/68</b>  |  |  |  |  |                             |
| 22d. PHYSICIAN'S NAME (Type) <b>Lilia C. Baldonado</b>  |  |  |   |  |  | 22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>   |  |  |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>7/26/68/</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Ottensbein Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Glenville, West Virginia</b>                |  |  |  |                             |
| 24. FUNERAL DIRECTOR <b>Wm. Cook-B ooks T wson 1050 York Rd. 21204</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR <b>JUL 26 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                    |  |  |                             |

80300

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |   |   |   |   |   |   |                                |  |
|--|--|---|---|---|---|---|---|---|---|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |   |   |   |   |   |   |                                |  |
| 09600 CERTIFICATE OF DEATH 09609   |  |   |   |   |   |   |   |   |   |   |                                |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Virginia Klein</i>  |  |   |   |   | 2a. DATE OF DEATH<br>Month <i>July</i> Day <i>11</i> , Year <i>1968</i>   |   |   | 2b. HOUR<br><i>7:40A</i>  |   |   |                                |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>                       |   | 5. DATE OF BIRTH<br><i>July 24, 1910</i>  |   |   | 6. AGE (In years last birthday)<br><i>57</i> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                      |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i>  |   |   |   |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>1308 Glenwilde Rd.</i> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>    |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  |   | 13b. COUNTY<br><i>Balto.</i>  |   | 13c. CITY OR TOWN<br><i>Catonsville</i>                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>1308 Glenwilde Rd.</i> |   |                                |  |
| 14. FATHER'S NAME<br>First <i>Henry</i> Middle <i>Schneider</i>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>First <i>Alanta</i> Middle <i>Polson</i>      |   |   |   |   |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)   |  |   | 16b. SOCIAL SECURITY NO.<br><i>217-26-1589</i>  |   | 17. INFORMANT<br>Address<br><i>Mr. George G. Klein-1308 Glenwilde Rd.</i> |   |   |   |   |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Melanoma, metastatic, original site unknown</i><br><i>1729</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 1/2 yrs.</i> |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>1909</i>   |  |   |   |   |   |   |   |   |   |   |                                |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |   |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                             |   |   |   |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |   |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb.</i> , 19 <i>66</i> , to <i>July</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |   |   |   |   |   |   |   |   |                                |  |
| 22b. SIGNATURE<br><i>Leo J. Gaver, M.D.</i><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |   |   |   | 22c. DATE SIGNED<br><i>July 12, 1968</i>  |   |   |   |   |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Leo J. Gaver, M.D.</i>  |  |   |   |   |   | 22e. ADDRESS<br><i>1 Mallow Hill Ave., Baltimore, Md.</i>   |   |   |   |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>July 13, 1968</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn</i>                     |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Woodlawn Balto. Md.</i> |   |   |                                |  |
| 24. FUNERAL DIRECTOR<br><i>John T. Stansbury, Sr.</i><br>ADDRESS<br><i>-6411 Windsor Mill Rd.</i>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br><i>JUL 15 1968</i>                             |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |   |   |                                |  |

2432

0025

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |                                    |   |  |  |  |        |      |
|--|--|------------------------------|--|--|------------------------------------|---|--|--|--|--------|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                    |   |  |  |  |        |      |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                    |   |  |  |  |        |      |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  | Middle   | Last                               | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR   |  |        |      |
| MARIE A. KOERMER   |  |                              |  |  |                                    | JULY 25 1968  |  | 8 A M  |  |        |      |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  |        |      |
| F  |  | W                            |  | MAR 7, 1896  |                                    | 72 YRS.   |  |  |  |        |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  | Md.  |  |        |      |
| M  |  | USA                          |  |  |                                    | BALTO.  |  |  |  |        |      |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |        |      |
| ESSEX  |  |                              | 408 VIRGINIA AVE   |  |                                    |   |  |  |  |        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |        |      |
| MD   |  |                              | BALTO  |  | ESSEX                              |   |  |  | 408 VIRGINIA AVE   |        |      |
| 14. FATHER'S NAME  |  |                              | First  | Middle   | Last                               | 15. MOTHER'S MAIDEN NAME  |  |  | First  | Middle | Last |
|  |  |                              |  |  | KLINGELHOFER                       |   |  |  |  |        | ?    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | (If yes give war or dates of service)  |  |                                    | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT Address  |        |      |
| NO   |  |                              |  |  |                                    |   |  |  | GERTRUDE BECKER 404 VIRGINIA                                     |        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                              |  |  |                                    |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS<br>14 YRS |        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200   |  |                              |  |  |                                    |   |  |  |  |        |      |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |        |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |        |      |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |        |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 30, 1963</u> , to <u>JULY 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>JULY 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |  |  |                                    |   |  |  |  |        |      |
| 22b. SIGNATURE   |  |                              | DEGREE   |  |                                    | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED   |        |      |
| JOSEPH MICELI M.D.   |  |                              |  |  |                                    |   |  |  | 7/26/68  |        |      |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              | 22e. ADDRESS   |  |                                    |   |  |  |  |        |      |
| JOSEPH MICELI M.D.   |  |                              | 108 S. TAYLOR AVE ESSEX, MD. 21221   |  |                                    |   |  |  |  |        |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION (City or Town) (County) (State)                        |  |        |      |
| BURIAL   |  |                              | 7/29/68  |  | OAK LAWN                           |   |  | BALTO. MD  |  |        |      |
| 24. FUNERAL DIRECTOR   |  |                              | ADDRESS  |  |                                    | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |        |      |
| J.G. CONNELLY SONS   |  |                              | 300 MACE   |  |                                    | DATE JUL 30 1968  |  | J. Charles Jones   |  |        |      |

01380

00800

RECORDS IN 1938

1938

1938

RECORDS IN 1938

RECORDS IN 1938

RECORDS IN 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09611

|   |  |   |   |   |
|---|--|---|---|---|
| 1. DECEASED-NAME<br>(Type or print) First <u>Caroline</u> Middle <u>Katherine</u> Last <u>Kohler</u>  |  | 2a. DATE OF DEATH<br>Month <u>July</u> Day <u>16</u> Year <u>1968</u>   |   | 2b. HOUR <u>PM</u> MIN. <u>3:25</u>   |
| 3. SEX<br><u>female</u>   | 4. RACE<br><u>white</u>  | 5. DATE OF BIRTH<br><u>July 22, 1900</u>  | 6. AGE (In years last birthday)<br><u>67</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                     |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Md.</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><u>Baltimore</u>  |   |
| 10. CITY OR TOWN OF DEATH<br><u>Catonsville</u>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>SPRING GROVE STATE HOSP.</u>   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>housewife</u> | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Md.</u>   |  | 13b. COUNTY<br><u>Harford</u>   | 13c. CITY OR TOWN<br><u>Abingdon</u>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME First <u>George</u> Middle <u>Spies</u> Last <u>Spies</u>   |  | 15. MOTHER'S MAIDEN NAME First <u>Caroline</u> Middle <u>Anna</u> Last <u>Novotny</u>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <u>no</u> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><u>214-20-8205</u>  | 17. INFORMANT<br><u>Records: SPRING GROVE STATE HOSPITAL</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute, death,</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>with previous antero-septal M.I.</u><br>(b) <u>Arteriosclerotic cardiovascular ht. dis.</u> <u>3 yrs.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis, Generalized, Senile</u> <u>3 yrs.</u> |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>a-Pneumonitis, Rt. Lung, org.Unk.; b-arteriolar nephrosclerosis.</u>   |  |   |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 27, 1965</u> , to <u>July 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |
| 22b. SIGNATURE<br><u>Anthony J. Young, MD</u>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22c. DATE SIGNED<br><u>PM 16 July '68 4:00</u>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Anthony J. Young, MD</u>   |  | 22e. ADDRESS<br><u>SPRING GROVE STATE HOSPITAL</u><br><u>Baltimore, Maryland 21228</u>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>July 18, 1968</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Francis Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Abingdon Harford Md</u>                                 |   |
| 24. FUNERAL DIRECTOR<br><u>Howard K. McComas &amp; Son, Abingdon, Md.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>JUL 19 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |

413

108

100



1  
M  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09603

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09612

## CERTIFICATE OF DEATH

|   |                         |  |  |   |  |
|---|-------------------------|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First <b>Anthony</b> Middle <b>John</b> Last <b>Kostenbauer</b>   |                         |  | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>15</b> Year <b>1968</b>            |   | 2b. HOUR A.M. <b>7:10</b>                        |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br><b>7-9-68</b>  |   | 6. AGE (In years lost birthday)<br><b>6</b> YRS. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>Baltimore</b>  |                         | Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>none</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |                         |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |                         | 13e. STREET AND NUMBER<br><b>209 N. Rock #444 Rd.</b>  |  | <b>21229</b>  |  |
| 14. FATHER'S NAME First <b>John</b> Middle <b>H.</b> Last <b>Kostenbauer</b>  |                         |  | 15. MOTHER'S MAIDEN NAME First <b>Joyce</b> Middle <b>A.</b> Last <b>Rainier</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>John H. Kostenbauer, Rock Glen Rd. 21229</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7777X</b> IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>776X</b>   |                         |  |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-9-68</b> , 19____, to <b>7-15-68</b> , 19____, that (I) (we) last saw the deceased alive on <b>7-15-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |                         |  |  |   |  |
| 22b. SIGNATURE<br><b>Jose A. Aguto</b>  |                         | DEGREE<br><b>MD</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |
| 22c. DATE SIGNED<br><b>7-15-68</b>  |                         |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Jose Aguto, M.D.</b>   |                         | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REINTERMENT<br><b>Burial</b>  |                         | 23b. DATE<br><b>7-16-1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Md.</b>   |                         |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md</b>  |                         | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 18 1968</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                         |  |  |   |  |

1931

1931



1931

1931

John A. ...

1931

1931

1931

7-10-31 ...

George ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |   |                                       |
|---|--|--|--|---|--|---|--|--|---|---------------------------------------|
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |   |                                       |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>JAMES</b>  |   | Middle<br><b>J</b>   |   | Last<br><b>KOTSCHENREUTHER</b>                                       |  | 2a. DATE OF DEATH<br>Month <b>JULY</b> Day <b>29</b> Year <b>1968</b> | 2b. HOUR<br><b>12:45</b> <sup>A</sup> |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>APRIL 28, 1888</b>   |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |   | IF UNDER 24 HRS.<br>HOURS MIN.        |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |   |                                       |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMIN HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RESTAURANT WORKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |                                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>415 S ELLWOOD AVE</b> |   |                                       |
| 14. FATHER'S NAME<br>First <b>ANDREW</b> Middle <b>KOTSCHENREUTHER</b> Last <b>ANTONELLI</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ANTONELLI</b> Middle <b>ANTONELLI</b> Last <b>ANTONELLI</b> |   |  |   |  |  |   |                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219 30 5514</b>   |  | 17. INFORMANT<br>Address <b>CLINICAL RECORDS, VA HOSP, FT HOWARD, MD</b>  |  |   |  |  |   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>(c) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b><br>YEARS |  |  |  |   |  |   |  |  |   |                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4200</b>  |  |  |  |   |  |   |  |  |   |                                       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |                                       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |                                       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |   |                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/15/68</b> , 19____, to <b>7/29/68</b> , 19____, that <b>(I)</b> (we) last saw the deceased alive on <b>7/29/68</b> , 19____, and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |   |                                       |
| 22b. SIGNATURE<br><i>Peter V. Juvan</i>   |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>7/29/68</b>  |  |  |   |                                       |
| 22d. PHYSICIAN'S NAME (Type)<br><b>PETER V. JUVAN, M. D.</b>  |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |  |   |  |   |  |  |   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-1-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEMETER</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>GERMAN HILL RD. BALTO.MD.</b>               |  |  |   |                                       |
| 24. FUNERAL DIRECTOR<br>ADDRESS <b>LILLY &amp; ZEILER FUNERAL HOME</b> DATE <b>JUL 31 1968</b><br><b>CONKLING &amp; EASTERN AVE. BALTIMORE, MD.</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>   |  |  |  |   |  |   |  |  |   |                                       |

MEDICAL CERTIFICATION

21220

2113

WEEK OF 1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |   |  |
|---|--|---|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or print) Sarah   |  |   | First Middle Last Kotz                                      |   |  | 2a. DATE OF DEATH<br>Month 7 Day 16 Year 68  |   | 2b. HOUR<br>11 p.m.   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>5/23/02   |  | 6. AGE (In years<br>last birthday)<br>66 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>RUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Pikesville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>PROFESSIONAL HOUSE |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>AT HOME                                      |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Washington D.C.   |  | 13b. COUNTY<br>✓  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>1616-<br>Woodner Apts-16th St NW      |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Louis Gilman  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>ANNIE Kotz |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                     |   | 17. INFORMANT<br>Address<br>DR. LEONARD KOTZ, 6106 BENHURST RD. #21209  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma presumably of the pancreas</u><br>1579 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>About 2 mos. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>157x   |  |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/18, 1967</u> , to <u>7/17, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>7/17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><u>J. Elliot Levi M.D.</u>  |  | DEGREE<br>M.D.  |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  | 22c. DATE SIGNED<br>7/18/68  |   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. J. Elliot Levi   |  | 22e. ADDRESS<br>222 W. Cold Spring Lane   |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>REMOVAL-BURIAL  |  | 23b. DATE<br>7-18-68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>KING DAVID  |  | 23d. LOCATION (City or Town) (County) (State)<br>FALLS CHURCH, VIRGINIA              |   |   |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE JUL 22 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                   |   |   |  |

1960

1961

STATE OF TEXAS

County of \_\_\_\_\_  
City of \_\_\_\_\_  
State of \_\_\_\_\_  
U.S.A.

Personal and Confidential  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
U.S.A.

\_\_\_\_\_

\_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then make remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |   |  |   |   |  |                                   |                            |                                   |  |
|---|--|---|--|--|--|---|--|---|---|--|-----------------------------------|----------------------------|-----------------------------------|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |   |  |                                   |                            |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br><b>EDWARD</b>   |  |  | Middle<br><b>ANTHONY</b>  |  | Last<br><b>KOVAL</b>  |   | 2a. DATE OF DEATH<br>Month <b>7</b> Day <b>29</b> Year <b>68</b> |                                   | 2b. HOUR<br><b>11:00AM</b> |                                   |  |
| 3. SEX<br><b>MALE</b>   |  |   | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br><b>4/23/24</b>  |  |   | 6. AGE (In years<br>last birthday)<br><b>44</b> YRS.        |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |                            | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>BALTIMORE, MARYLAND</b>  |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b>              |  |                                   |                            | Md.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>VET. ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>MACHINIST</b>  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>WOOD COMPANY</b> |  |                                   |                            |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>603 Umbra Street</b>                |                                   |                            |                                   |  |
| 14. FATHER'S NAME<br>First<br><b>JOHN</b>   |  |   | Middle<br><b>KOVAL</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>AGNES</b>   |  |   | Middle<br><b>BROCKI</b>                                     |  |                                   | Last                       |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>YES</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>21912 60 84</b>   |  |  | 17. INFORMANT<br>Address<br><b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |   |   |  |                                   |                            |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF MOUTH WITH METASTASES</b><br><b>TO LUNGS, LIVER, SPLEEN, HEART AND LYMPH NODES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |                                   |                            |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>144X</b>   |  |   |  |  |  |   |  |   |   |  |                                   |                            |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>YES</b>              |   |  |                                   |                            |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |  |   |  |   |   |  |                                   |                            |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                   |  |   |  |   |   |  |                                   |                            |                                   |  |
| 22a. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>6/11/68</b> , 19____, to <b>7/29/68</b> , 19____, that <b>(H)</b> (we) last<br>saw the deceased alive on <b>7/29/68</b> , 19____, and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <b>(H)</b> (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |   |  |                                   |                            |                                   |  |
| 22b. SIGNATURE<br><b>George C. McElpatrick, M.D.</b>  |  |   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>7/29/68</b>  |   |  |                                   |                            |                                   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |   |   |  |                                   |                            |                                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/1/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NAT'L Cem</b>               |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Beltz Md</b>  |  |   |   |  |                                   |                            |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>J N Zannino</b>  |  |   |  |  |  |   |  |   |   |  |                                   |                            |                                   |  |
| 25a. REC'D BY REGISTRAR<br><b>ZANNINO FUNERAL HOME</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b><br>DATE <b>JUL 31 1968</b><br>25c. ADDRESS<br><b>257 S. Conkling Street, Baltimore, Md.</b>  |  |   |  |  |  |   |  |   |   |  |                                   |                            |                                   |  |

30322

DEPARTMENT OF HEALTH

100-10015

| NAME     | AGE | SEX | RACE | RELIGION | EDUCATION | OCCUPATION | RESIDENCE   | DATE OF BIRTH | DATE OF DEATH | CAUSE OF DEATH | PLACE OF DEATH | DATE OF BURIAL | PLACE OF BURIAL | DATE OF CREMATION | PLACE OF CREMATION | DATE OF INTERMENT | PLACE OF INTERMENT |
|----------|-----|-----|------|----------|-----------|------------|-------------|---------------|---------------|----------------|----------------|----------------|-----------------|-------------------|--------------------|-------------------|--------------------|
| JOHN DOE | 45  | M   | W    | C        | H         | DRIVER     | 123 MAIN ST | 1910-01-01    | 1955-03-15    | HEART DISEASE  | HOSPITAL       | 1955-03-20     | CEMETERY        |                   |                    |                   |                    |
| JANE DOE | 42  | F   | W    | C        | H         | HOUSEWIFE  | 123 MAIN ST | 1910-01-01    | 1955-03-15    | HEART DISEASE  | HOSPITAL       | 1955-03-20     | CEMETERY        |                   |                    |                   |                    |
| JOHN DOE | 45  | M   | W    | C        | H         | DRIVER     | 123 MAIN ST | 1910-01-01    | 1955-03-15    | HEART DISEASE  | HOSPITAL       | 1955-03-20     | CEMETERY        |                   |                    |                   |                    |
| JANE DOE | 42  | F   | W    | C        | H         | HOUSEWIFE  | 123 MAIN ST | 1910-01-01    | 1955-03-15    | HEART DISEASE  | HOSPITAL       | 1955-03-20     | CEMETERY        |                   |                    |                   |                    |



100-10015  
JUL 1 1955  
U.S. DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|--------------------------------|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 09607   |  |  |  |  |  |   |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                     |  |  |  |   |  |  |  |                                |  |  |  | 09617                        |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Margaret H. Lake</b>  |  |  |  |  |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>July 11 1968</b>                                      |  |  |  |   |  |  |  |                                |  |  |  | 2b. HOUR<br>M<br><b>5:42</b> |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>F</b>  |  |  |  | 4. RACE<br><b>W</b>  |  |   |  | 5. DATE OF BIRTH<br><b>8/28/1899</b>  |  |  |  | 6. AGE (In years last birthday)<br><b>68</b> YRS.   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore 21212</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Armocost Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |   |  | 13c. CITY OR TOWN<br><b>Balto. 12</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br><b>710 Dunkirk Road</b> |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William S. Hess</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Bessie Wagner</b> |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-1622B</b>  |  |   |  | 17. INFORMANT<br><b>Paul S. Lake</b>  |  |  |  | Address<br><b>(Same)</b>  |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4500</b>  |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  |   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 17, 1968</b> , to <b>July 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.                                       |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Laurence C. Post M.D.</b>  |  |  |  | DEGREE<br><b>DEGREE</b>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  |  | 22c. DATE SIGNED<br><b>7-11-68</b>  |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Laurence C. Post</b>   |  |  |  | 22e. ADDRESS<br><b>6805 York Road</b>  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>7/13/68</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Balto. Co., Md.</b>               |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>  |  |  |  | ADDRESS<br><b>4905 York Road</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 11 1968</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Carlos J. J.</b>  |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |
| BALTO. 12, MD.  |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |

610

5530

6. =

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90  
30  
4

2

1

| Item 13e Urshome Phone 7267000 MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |   |  |
| 09608 CERTIFICATE OF DEATH 09618   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br>Rosie Mabel Langford   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>7 18 1968                   |   |  |   | 2b. HOUR<br>61 M   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>5-8-81  |  | 6. AGE (In years last birthday)<br>87 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonville Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)<br>Shangri La-Maryland |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3516 Caton Ave. |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Harry Britton  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Cecile Mary Hurle |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>214-01-6893                            |   | 17. INFORMANT<br>Address<br>Mr. William S. Langford 1912 Woodbourne Ave.   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myelogenous Leukemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>403X</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Posterior Nephrosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u> |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Bacterial Pneumonia - Staphylococcus Infection</u>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 5</u> , 19 <u>68</u> , to <u>July 18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Charles Judge</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  |   | 22e. ADDRESS<br><u>812 Mockingbird Lane</u>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>7/22/68i   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Western Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  |   |  |   | 25a. RECD BY REGISTRAR<br>DATE JUL 25 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |   |  |

81080

81080

557

Handwritten signature

800 22 100



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIPPED TO: WAUGH, HOLLEY & WOOD FUNERAL HOME, GALLITPOLIS, OHIO

09609

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09620

|   |         |   |  |   |                                |   |                              |  |  |   |          |
|---|---------|---|--|---|--------------------------------|---|------------------------------|--|--|---|----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |  | Middle  |                                | Last  |                              | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 7/9/ 19 68 |  | 2b. HOUR<br>7:10 PM                                       |          |
| DAVID   |         | VINCENT   |  | LAWSON  |                                | SR.   |                              |  |  |   |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS<br>HOURS MIN |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |   | 2d. HOUR |
| Male  | White   | 12/2/23   |  | 44 YRS.   |                                |   |                              |  | July 9 19 68                               |   | 7:10 PM  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                | 9. COUNTY OF DEATH  |                              |  |  |   |          |
| West Virginia   |         | U.S.A.  |  |   |                                | Baltimore   |                              |  |  |   |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)         |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                              |  |  |   |          |
| Fort Howard   |         | Veterans Administration Hospital  |  | Svc. Sta. Attendant Station   |                                | Gas   |                              |  |  |   |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET AND NUMBER   |  |   |          |
| Maryland  |         |   |  | Baltimore   |                                |   |                              | 709 St. Paul Street  |  |   |          |
| 14. FATHER'S NAME   |         | First   |  | Middle  |                                | Last  |                              | 15. MOTHER'S MAIDEN NAME   |  | First Middle Last   |          |
| John M.   |         | Lawson  |  |   |                                |   |                              | Nellie   |  | Parcell   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |                                | ADDRESS   |                              |  |  |   |          |
| Yes   |         | WW II   |  | Unk.  |                                | Clin. Rec. VAH, Fort Howard, Maryland   |                              |  |  |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHIAL PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>2ND DEGREE BURNS HANDS ARMS CHEST AND FACE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |         |   |  |   |                                |   |                              |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>7 DAYS |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>9160   |         |   |  |   |                                |   |                              |  |  |   |          |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                                    |  | 20. AUTOPSY?  |                                |   |                              |  |  |   |          |
| 7/3/68  |         | Difficulty in breathing   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |   |                              |  |  |   |          |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 6/28/ 19 68                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>At Home - EX House Fire  |                                |   |                              |  |  |   |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Home |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>709 St. Paul St. Baltimore, Maryland  |                                |   |                              |  |  |   |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |  |   |                                |   |                              |  |  |   |          |
| ACTUAL<br>SIGNATURE   |         | EXAMINER'S<br>NAME (Type)   |  | 22b. DATE SIGNED  |                                |   |                              |  |  |   |          |
| MB Davis  |         | MELVIN B. DAVIS, M.D.   |  | 7/9/68  |                                |   |                              |  |  |   |          |
| 23a. BURIAL CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                | 23d. LOCATION (City or Town) (County) (State)   |                              |  |  |   |          |
| Burial  |         | 7/13/68   |  | Cunningham Mem. Cem.  |                                | S. Charleston, W. Va.   |                              |  |  |   |          |
| 24. FUNERAL DIRECTOR  |         | Leonard J. 5305   |  | RUCK FUNERAL HOME<br>HARFORD ROAD, BALTIMORE, MD. 21211   |                                | 25a. RECEIVED BY REGISTRAR  |                              | 25b. RECEIVED BY REGISTRAR   |  |   |          |

08050

08050

WOMAN EXAMINER: JENNIFER M. LAMON

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

*Handwritten signature*

1000 - 1000

1000 - 1000

1000 - 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514  
30M REV. 7/68

|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 09610  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 09621   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>GRACE MCGOWAN LAZENBY</b>   |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH<br><b>7</b> Month <b>10</b> Day <b>1968</b>   |  |  |  |  |   |  |  |  |  | 2b. HOUR <b>1:40</b> AM   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>F</b>   |  |  |  |  | 4. RACE<br><b>CAU</b>   |  |  |  |  | 5. DATE OF BIRTH<br><b>1-22-22</b>  |  |  |  |  | 6. AGE (In years last birthday)<br><b>72</b> YRS.   |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN                        |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE MD.</b>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GBMC 6701 N. CHARLES ST.</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  |  |  |  | 13b. COUNTY<br><b>BALTO.</b>  |  |  |  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br><b>914 BELGIAN AVE.</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>WILLIAM MCGOWAN</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>ROSE WHITTAKER</b>   |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)   |  |  |  |  |   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-34-7859</b>  |  |  |  |  | 17. INFORMANT<br><b>MEDICAL RECORD CHART</b> Address |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1580</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>RETROPERITONEAL SARCOMA</b><br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)         |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>158x</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-08</b> , 19 <b>68</b> , to <b>7-10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-10</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  | 22b. SIGNATURE<br><b>Meshkinpour M.D.</b> DEGREE<br><b>DR. MESHKINPOUR</b>  |  |  |  |  |   |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br><b>7/10/68</b>                   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. MESHKINPOUR</b>   |  |  |  |  | 22e. ADDRESS<br><b>GBMC 6701 N. CHARLES ST.</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  | 23b. DATE<br><b>7-12-68</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Balto. Md.</b>                  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Henry W. Jenkins &amp; Sons Co. Balto., Md.</b>   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1968</b>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |  |                                   |                                |  |
|---|--|---|---|---|--|--|--|-----------------------------------|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |  |                                   |                                |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |  |                                   |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First MARY R. Middle LEACH Last                               |   |  | 2a. DATE OF DEATH<br>Month 7 Day 22 Year 68  |  |                                   | 2b. HOUR<br>M                  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>Unknown   |  |  | 6. AGE (In years last birthday)<br>80 YRS.                           |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS | IF UNDER 24 HRS.<br>HOURS MIN.               |
| 7a. BIRTHPLACE (State or foreign country)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE              |  |                                   | Md.                            |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SUMMIT NURSING HOME |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |  | 13b. CITY OR TOWN<br>BALTIMORE  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>3009 GUILFORD AVE. |  |                                   |                                |  |
| 14. FATHER'S NAME<br>First Marshall M. Middle ELDER Last  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Mary Jane Lilly Middle Last |   |  |  |  |                                   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                   |   | 17. INFORMANT<br>Address<br>SOLOMON LEACH, JR. 808 N. MARLYN AVE. 21221   |  |  |  |                                   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis CVA @</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Anemysm</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cronary Arteriosclerosis</u> |  |   |   |   |  |  |  |                                   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201   |  |   |   |   |  |  |  |                                   |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                                   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat white <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                                   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1966, to July 22, 1968, that (I) (we) last saw the deceased alive on 5/24/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.   |  |   |   |   |  |  |  |                                   |                                |  |
| 22b. SIGNATURE<br>John C. Healy   |  | 22c. DATE SIGNED<br>7/23/68   |   |   | 22d. PHYSICIAN'S NAME (Type)<br>JOHN C. HEALY  |  |  |                                   |                                |  |
| 22e. ADDRESS<br>1311 FRANCIS AVE. 21227   |  |   |   |   |  |  |  |                                   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>7-25-68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO., MD.         |                                   |                                |  |
| 24. FUNERAL DIRECTOR<br>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE JUL 24 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |                                   |                                |  |

02823

RECEIVED

157





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09612

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item#22c,d, Film#461 7/23/73 kam

09623

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>Balto City</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Balto Co Catonsville</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Paradise Nursing Home</b>   |                                     | d. STREET ADDRESS<br><b>1619 Belt St</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>WILLIAM FREDERICK LEEP</b>   |                                     | 4. DATE OF DEATH Month Day Year<br><b>JULY 18 1968</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>W</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr 11, 1890</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>70</b>  |                                     | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>IF UNDER 24 HRS.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>No</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>So States</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>W.Va.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Flora Becker</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                     | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Family</b>   |                                     | Address<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>486X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c) |                                     | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>493X CARCINOMA LARGE BOWEL</b>   |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>6-4</b> , 19 <b>68</b> , to <b>7-18</b> , 19 <b>68</b> , that I last saw the deceased alive on <b>7-17</b> , 19 <b>68</b> , and that death occurred at <b>3:40</b> A.M. from the causes and on the date stated above.                       |                                     |  |  |
| ACTUAL SIGNATURE <b>Dr. Sorongon</b> M.D.  |                                     | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>3915 HOLLINS FERRY RD. BALTO., MD. 21227 7/18/68</b>                                     |  |
| PHYSICIAN'S NAME (Type) <b>DOMINGO C. SORONGON M.D.</b>  |                                     |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>7/22/68</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem. Clarksburg Cem</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md. Clarksburg, W.Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Mc Culley F. H. 130 E. Front Ave.</b>   |                                     | 24a. REC'D BY REGISTRAR DATE<br><b>JUL 19 1968</b>   |  |
| ADDRESS<br><b>211230</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| Item 18-1m 403 8-9-68<br>09613<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br><b>CERTIFICATE OF DEATH</b><br>09624  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Grace A. Leisure</b>  |  |  |  |   | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>19</b> Year <b>1968</b>  |   |  | 2b. HOUR<br><b>10:00</b> AM                                      |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>March 6, 1911</b>  |  | 6. AGE (In years lost birthday)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1905 Rettman Lane</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Manager Beauty Salon</b>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 13e. STREET AND NUMBER<br><b>1615 Four Georges Court</b>         |  |
| 14. FATHER'S NAME<br>First <b>Tilden</b> Middle <b>Waller</b> Last <b>Waller</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Edna</b> Middle <b>Whorton</b> Last <b>Whorton</b>                        |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, No, or (unknown) <b>No</b> (If yes give war or dates of service) |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-01-6178</b>   |  |  | 17. INFORMANT (Husband) <b>Earl D. Leisure Sr.</b> Address <b>Dundalk, Md.</b><br><b>1615 Four Georges Ct.</b> |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>154X</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/12</b> , 19 <b>68</b> , to <b>7/19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Theodore C. Patterson</b>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>July 19, 1968</b>                             |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Theodore C. Patterson</b>   |  |  |  |   | 22e. ADDRESS<br><b>3724 Dundalk Ave. Dundalk, Md. 21222</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/22/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 22 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |

08854

11011

TO THE  
FROM THE  
DATE  
SUBJECT  
REMARKS  
INITIALS  
SIGNATURE  
OFFICIAL  
OFFICE

1. The first part of the report is a general statement of the facts of the case. It is a summary of the information received from the complainant and the witnesses. It is a statement of the facts as they are known to the investigating officer at the time of the report.

2. The second part of the report is a statement of the evidence. It is a statement of the facts as they are known to the investigating officer at the time of the report. It is a statement of the facts as they are known to the investigating officer at the time of the report.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |  |  |
|---|--|---|---|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |  |  |
| 09614   |  |   |   |   |  |  |   |  |  |
| 09625   |  |   |   |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last   |   |  | 2a. DATE OF DEATH<br>Month Day Year  |   |  | 2b. HOUR   |
| Blanche   |  |   | (nee Soper) Leonard   |   |  | July 28 1968   |   |  | M  |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |
| Female  |  | White   |   | Feb. 28, 1887   |  |  | 81 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN                                    |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |  |  |
| Baltimore   |  | USA   |   |   |  | Baltimore County, Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                             |
| Baltimore County  |  |   | Shady Nook Nursing Home   |   |  | Housewife  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |
| Maryland  |  |   | 13b. COUNTY   |   | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  | 821 Woodington Rd. (29)  |
| 14. FATHER'S NAME<br>First Middle Last  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last                                      |   |  |  |   |  |  |
| (late) Milburn Soper  |  |   | --  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |   |  |  |
| No.   |  |   | --  |   | Mrs. John C. Ward, 1241 Newfield Rd. 21207   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PNEUMONIA - BRONCHIAL</u><br><u>4409</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS - GEN'L</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 yrs</u> |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4500</u>   |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |
|   |  |   |   |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
|   |  |   |   |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
|   |  |   |   |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1968</u> , to <u>July 28, 1968</u> , that (I) (we) lost<br>saw the deceased alive on <u>July 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Norman R. Kleinman</u>   |  |   |   |   | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>7/29/68</u>  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>Norman R. Kleinman</u>   |  |   |   |   | 22e. ADDRESS<br><u>3803 Edmondson Ave., Balto., Md. 29</u>   |  |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |
| Burial  |  | July 31, 1968   |   | Woodlawn Cemetery   |  |  | Baltimore Co., Maryland   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Witzke Fun. Director</u>   |  |   |   |   | ADDRESS<br><u>4101 Edmondson Av.<br/>Balto., 21229</u>   |  | 25a. RECEIVED BY REGISTRAR <u>JUL 30 1968</u> 25b. RECEIVED BY SIGNATURE <u>[Signature]</u>     |  |  |

48380

1972

UNITED STATES

|  |  |
|--|--|
| UNITED STATES                          |  |
| DEPARTMENT OF AGRICULTURE              |  |
| OFFICE OF THE SECRETARY                |  |
| WASHINGTON, D. C. 20250                |  |
| DATE: 10/10/72                         |  |
| TO: DIRECTOR, ARS                      |  |
| FROM: ASSISTANT SECRETARY FOR RESEARCH |  |
| SUBJECT: ARS-1000-1000                 |  |
| RE: ARS-1000-1000                      |  |
| 1. ARS-1000-1000                       |  |
| 2. ARS-1000-1000                       |  |
| 3. ARS-1000-1000                       |  |
| 4. ARS-1000-1000                       |  |
| 5. ARS-1000-1000                       |  |
| 6. ARS-1000-1000                       |  |
| 7. ARS-1000-1000                       |  |
| 8. ARS-1000-1000                       |  |
| 9. ARS-1000-1000                       |  |
| 10. ARS-1000-1000                      |  |
| 11. ARS-1000-1000                      |  |
| 12. ARS-1000-1000                      |  |
| 13. ARS-1000-1000                      |  |
| 14. ARS-1000-1000                      |  |
| 15. ARS-1000-1000                      |  |
| 16. ARS-1000-1000                      |  |
| 17. ARS-1000-1000                      |  |
| 18. ARS-1000-1000                      |  |
| 19. ARS-1000-1000                      |  |
| 20. ARS-1000-1000                      |  |
| 21. ARS-1000-1000                      |  |
| 22. ARS-1000-1000                      |  |
| 23. ARS-1000-1000                      |  |
| 24. ARS-1000-1000                      |  |
| 25. ARS-1000-1000                      |  |
| 26. ARS-1000-1000                      |  |
| 27. ARS-1000-1000                      |  |
| 28. ARS-1000-1000                      |  |
| 29. ARS-1000-1000                      |  |
| 30. ARS-1000-1000                      |  |
| 31. ARS-1000-1000                      |  |
| 32. ARS-1000-1000                      |  |
| 33. ARS-1000-1000                      |  |
| 34. ARS-1000-1000                      |  |
| 35. ARS-1000-1000                      |  |
| 36. ARS-1000-1000                      |  |
| 37. ARS-1000-1000                      |  |
| 38. ARS-1000-1000                      |  |
| 39. ARS-1000-1000                      |  |
| 40. ARS-1000-1000                      |  |
| 41. ARS-1000-1000                      |  |
| 42. ARS-1000-1000                      |  |
| 43. ARS-1000-1000                      |  |
| 44. ARS-1000-1000                      |  |
| 45. ARS-1000-1000                      |  |
| 46. ARS-1000-1000                      |  |
| 47. ARS-1000-1000                      |  |
| 48. ARS-1000-1000                      |  |
| 49. ARS-1000-1000                      |  |
| 50. ARS-1000-1000                      |  |
| 51. ARS-1000-1000                      |  |
| 52. ARS-1000-1000                      |  |
| 53. ARS-1000-1000                      |  |
| 54. ARS-1000-1000                      |  |
| 55. ARS-1000-1000                      |  |
| 56. ARS-1000-1000                      |  |
| 57. ARS-1000-1000                      |  |
| 58. ARS-1000-1000                      |  |
| 59. ARS-1000-1000                      |  |
| 60. ARS-1000-1000                      |  |
| 61. ARS-1000-1000                      |  |
| 62. ARS-1000-1000                      |  |
| 63. ARS-1000-1000                      |  |
| 64. ARS-1000-1000                      |  |
| 65. ARS-1000-1000                      |  |
| 66. ARS-1000-1000                      |  |
| 67. ARS-1000-1000                      |  |
| 68. ARS-1000-1000                      |  |
| 69. ARS-1000-1000                      |  |
| 70. ARS-1000-1000                      |  |
| 71. ARS-1000-1000                      |  |
| 72. ARS-1000-1000                      |  |
| 73. ARS-1000-1000                      |  |
| 74. ARS-1000-1000                      |  |
| 75. ARS-1000-1000                      |  |
| 76. ARS-1000-1000                      |  |
| 77. ARS-1000-1000                      |  |
| 78. ARS-1000-1000                      |  |
| 79. ARS-1000-1000                      |  |
| 80. ARS-1000-1000                      |  |
| 81. ARS-1000-1000                      |  |
| 82. ARS-1000-1000                      |  |
| 83. ARS-1000-1000                      |  |
| 84. ARS-1000-1000                      |  |
| 85. ARS-1000-1000                      |  |
| 86. ARS-1000-1000                      |  |
| 87. ARS-1000-1000                      |  |
| 88. ARS-1000-1000                      |  |
| 89. ARS-1000-1000                      |  |
| 90. ARS-1000-1000                      |  |
| 91. ARS-1000-1000                      |  |
| 92. ARS-1000-1000                      |  |
| 93. ARS-1000-1000                      |  |
| 94. ARS-1000-1000                      |  |
| 95. ARS-1000-1000                      |  |
| 96. ARS-1000-1000                      |  |
| 97. ARS-1000-1000                      |  |
| 98. ARS-1000-1000                      |  |
| 99. ARS-1000-1000                      |  |
| 100. ARS-1000-1000                     |  |

101 30 608



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 09615   |  |  |  |  |   |  |  |  |   | MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |  |  |  | 09626 |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|---|--|--|--|--|--|---|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |   | CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First <i>Lena</i> Middle <i>[REDACTED]</i> Last <i>Levin</i>   |  |  |  |  | 2a. DATE OF DEATH Month <i>7</i> Day <i>18</i> Year <i>68</i>             |  |  |  |   | 2b. HOUR <i>1:30 PM</i>  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 3. SEX <i>Female</i>  |  |  | 4. RACE <i>White</i>   |  |   | 5. DATE OF BIRTH <i>XXXXXXXXXXXX</i>   |  |  | 6. AGE (In years last birthday) <i>66 1/2</i> YRS.                                |  |  | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>            |  |  | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Milford Manor Nursing Home</i> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>                                  |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>   |  |  | 13b. COUNTY <i>BALTIMORE</i>   |  |   | 13c. CITY OR TOWN <i>BALTO</i>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER <i>5029 QUEENSBERRY ROAD AV</i> |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <i>MANDEL</i> Middle <i></i> Last <i>LAZINSKY</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <i>ESTHER</i> Middle <i></i> Last <i>?</i> |  |  |  |   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>220-03-8440</i>                               |  |  |  |   | 17. INFORMANT Address <i>MR. HAROLD LEVIN, 2402 LIGHTFOOT DRIVE</i>            |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>Hypertension + Arteriosclerosis</i><br>(b) <i>Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF <i></i><br>(c) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4100</i> |  |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 day</i><br><i>3 years</i> |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201 none</i>   |  |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i></i> Day <i></i> Year <i>19</i>                               |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  |   | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>   |  |  |   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 30, 1965</i> to <i>July 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 15, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>Manuel Levin</i>  |  |  | DEGREE <i></i>   |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  | 22c. DATE SIGNED <i>7/18/68</i>   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN M.D.</i>   |  |  | 22e. ADDRESS <i>6101 PARK HEIGHTS AVE BALTO MD</i>   |  |   |  |  |  |   |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   |  |  | 23b. DATE <i>7-19-68</i>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY <i>NESINA</i>   |  |  | 23d. LOCATION (City or Town) (County) (State) <i>ROSEDALE, MARYLAND</i>           |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <i>XXKSOL LEVINSON &amp; BROS</i>  |  |  | ADDRESS <i>6010 REISTERSTOWN ROAD</i>  |  |   | 25a. REC'D BY REGISTRAR <i>JUL 22 1968</i>   |  |  | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>                                |  |  |  |  |  |   |  |  |  |  |       |  |  |  |  |  |  |  |  |  |

NAME: MANNES  
 LAST NAME: LARSEN  
 FIRST NAME: ESTHER  
 ADDRESS: 1400 LINDEN BLVD  
 CITY: NEW YORK, N.Y.  
 STATE: N.Y.  
 ZIP: 10017

Handwritten notes:  
 1/15/68  
 3/15/68  
 1/15/68  
 3/15/68

Handwritten notes:  
 1/15/68  
 3/15/68  
 1/15/68  
 3/15/68

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09616

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09627

|  |                         |   |   |   |   |  |  |  |  |   |
|--|-------------------------|---|---|---|---|--|--|--|--|---|
| 1. DECEASED-NAME<br>(Type or Print) <b>Joseph M. Levy</b>  |                         |   | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month <b>July</b> Day <b>17</b> Year <b>1968</b> |   |   | 2b. HOUR <b>8:15</b> a.m.  |  |  |  |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Jan. 18, 1928</b>  | 6. AGE (In years last birthday)<br><b>40</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD<br>Month <b>July</b> Day <b>17</b> Year <b>1968</b>   |  |  | 2d. HOUR<br><b>8:15</b> a.m.   |   |
| 7a. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  |   |
| 1d. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. Gen. Hosp.</b> |   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Proprietor</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Store</b> |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                         | 13b. COUNTY <b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>4702 Parmelee Road</b>      |  |   |
| 14. FATHER'S NAME<br>First <b>Isaac</b> Middle <b>Levy</b> Last <b>Levy</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Stella</b> Middle <b>Cohen</b> Last <b>Cohen</b>               |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>W.W.11 Air Force</b> |
| 17. INFORMANT<br><b>Mrs. Karleen Levy, 4702 Parmelee Rd.,</b>  |                         |   |   |   |   | ADDRESS <b>Balto. 21208 Md.</b>  |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>746.9 Congenital Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>746.9 Congenital Muscular Dystrophy</b><br>(b) <b>Congenital Muscular Dystrophy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congenital Muscular Dystrophy</b> |                         |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b><br><b>Unknown</b> |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>7545 Congenital Muscular Dystrophy</b>   |                         |   |   |   |   |  |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>7545</b>  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Congenital Muscular Dystrophy</b>           |   |   | 2d. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>none</b>   |                         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M. <b>19</b>                          |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>none</b>            |   |   | 21f. LOCATION Street or R.F.D. No. <b>6 Hanover Rd.</b> City or Town <b>Reisterstown, Md.</b> County <b>Baltimore</b> State <b>Md.</b> |  |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                |                         |   |   |   |   |  |  |  |  |   |
| ACTUAL SIGNATURE <b>D. D. Caples</b>   |                         |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | 22b. DATE SIGNED <b>7-17-68</b>  |  |  |  |   |
| EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>   |                         |   | 6 Hanover Rd.   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         |   | 23b. DATE<br><b>7-19-68</b>   |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>      |   |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |                         |   | ADDRESS   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 22 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>       |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit and please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |                            |  |  |
|---|--|--|--|---|--|---|--|---|----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |                            |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |                            |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>First Middle Last</i><br><i>Guy Lewis</i>  |  |  |  |   |  | 2a. DATE OF DEATH<br><i>July</i> Month <i>19</i> , Day <i>1968</i>  |  |   | 2b. HOUR<br><i>7:50 P.</i> |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>December 26, 1892</i>  |  | 6. AGE (In years lost birthday)<br><i>75</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                            | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Nebraska</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |   |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>603 Beverly Road</i>   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)<br><i>Retired Store Clerk</i> |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>  |  |  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Reisterstown</i>  |  | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                |                            | 13e. STREET AND NUMBER<br><i>603 Beverly Road</i>                              |  |
| 14. FATHER'S NAME <i>First Middle Last</i><br><i>Frederick E. Lewis</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME <i>First Middle Last</i><br><i>Susan Harden</i>  |  |   |  |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><i>No</i> (Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>215-28-8197</i>  |  | 17. INFORMANT Address<br><i>Mrs. Minnie C. Lewis Reisterstown, Md.</i>  |  |   |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i><br><i>1538</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastasis to liver</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i><br><i>1 year</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>1538</i>  |  |  |  |   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>67</i> , to <i>July 19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  |   |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><i>C. E. McElreath MD</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>7-19-68</i>  |                            |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>C. E. McElreath</i>  |  |  |  |   |  | 22e. ADDRESS<br><i>11904 Reisterstown Rd Reisterstown Md.</i>   |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>July 22, 68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Moreland Memorial</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i>  |  |   |                            |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><i>J. F. Eline &amp; Sons Reisterstown, Md.</i>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>JUL 22 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |                            |  |  |

85388

RECEIVED

1961

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows in several lines]

JUL 23 1961



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 09618   |  |  |  |  |   |  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH                  |  |  |  |  |   |  |  |  |  | 09624  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Alice M. Linzey   |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>July 15, 1968   |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>7 P M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>F   |  |  |  |  | 4. RACE<br>W  |  |  |  |  | 5. DATE OF BIRTH<br>6/22/1880   |  |  |  |  | 6. AGE (In years last birthday)<br>88 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Towson, Md.  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Chesapeake Manor N.H. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  |  | 13c. CITY OR TOWN<br>Towson   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>10 Nightingale Lane              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Edward D. Whittle  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Alice Ellen McDonald                                    |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>No  |  |  |  |  |   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>214-22-8698                    |  |  |  |  | 17. INFORMANT Address<br>Mr. Urban T. Linzey, Jr. 2114 Folkstone Rd. Timonium, Md. |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 ARTERIOSCLEROTIC HEART DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13/68, 19, to 7/16/68, 19, that (I) (we) last saw the deceased alive on 7/13/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |   |  |  |  |  | 22b. SIGNATURE<br>T. C. Siwinski  |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED<br>7/16/68                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Thaddeus Siwinski   |  |  |  |  | 22e. ADDRESS<br>206 W. Penna. Ave. Towson   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |  | 23b. DATE<br>7/18/68  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Monte Marie   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Balto Co. Md.                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.  |  |  |  |  |   |  |  |  |  | 25a. RECEIVED BY REGISTER<br>JUL 18 1968  |  |  |  |  |   |  |  |  |  | 25b. SIGNATURE<br>J. H. [Signature]                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

1971

STATE OF TEXAS

1971

1971

1971

1971

1971

1971

1971

1971

1971



1971

1971

1971

1971

1971



1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |  |               |  |                                |   |  |
|---|--|--|--------------------------|--|---------------|--|--------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |               |  |                                |   |  |
| CERTIFICATE OF DEATH  |  |  |                          |  |               |  |                                |   |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last        |  |               | 2a. DATE OF DEATH  |                                | 2b. HOUR  |  |
| Florence E. Long  |  |  |                          |  |               | 7 Month 6 Day 1968   |                                | M   |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |               | 6. AGE (In years lost birthday)  |                                | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| Female  |  | White  |                          | Jan. 26, 1896  |               | 72 YRS.  |                                |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. COUNTY OF DEATH   |                                |   |  |
| Mass.   |  | U. S. A.   |                          |  |               | Baltimore Md.  |                                |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |               | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |   |  |
| Haver Catonsville   |  | House in Pine Catonsville  |                          | Housewife  |               |  |                                |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER                                  |  |
| New Hampshire   |  |  |                          | Salem  |               |  |                                | 180 Main St.  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |               |  |                                |   |  |
| First Middle Last   |  |  | First Middle Last        |  |               |  |                                |   |  |
| William E. Dunbar   |  |  | Flossie                  |  |               |  |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT |  | Address                        |   |  |
| No  |  |  | 601-12-5337              |  | Damon Kenison |  | 7758 Bolton Loop Ft. Meade Md. |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |               |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |                          |  |               |  |                                |   |  |
| IMMEDIATE CAUSE (a) Carcinoma, Cervix, Inoperable   |  |  |                          |  |               |  |                                |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident  |  |  |                          |  |               |  |                                | 2 months  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction  |  |  |                          |  |               |  |                                | ?   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |                          |  |               |  |                                |   |  |
| 171X  |  |  |                          |  |               |  |                                |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          | 20a. AUTOPSY?  |               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |   |  |
|   |  |  |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>   |               |  |                                |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |               |  |                                |   |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |                          |  |               |  |                                |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |               |  |                                |   |  |
|   |  |  |                          |  |               |  |                                |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-15, 1968, to 7-5, 1968, that (I) (we) last saw the deceased alive on 7-5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |               |  |                                |   |  |
| 22b. SIGNATURE  |  |  |                          | 22c. DATE SIGNED   |               |  |                                |   |  |
| Rolando V. Goco, H.D. DEGREE  |  |  |                          | 7-5-68   |               |  |                                |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          | 22e. ADDRESS   |               |  |                                |   |  |
|   |  |  |                          | 707 E. Fort, Balt. Md 21230  |               |  |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |               | 23d. LOCATION (City or Town) (County) (State)  |                                |   |  |
| Burial  |  | 7/10/68  |                          | Pine Grove Cem   |               | Salem, New Hampshire   |                                |   |  |
| 24. FUNERAL DIRECTOR  |  |  |                          | 25a. REC'D BY REGISTRAR  |               | 25b. REGISTRAR'S SIGNATURE   |                                |   |  |
| Wm J. Tichner-Sont Balt, Md   |  |  |                          | JUL - 9 1968   |               | Charles Judge  |                                |   |  |

05388

RECORD OF VITALS FOR THE YEAR 1900

STATE OF OHIO

0131



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 17. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MEVS  
10M REV. 1-68

09620

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09631

|  |                  |   |   |   |  |  |  |   |
|--|------------------|---|---|---|--|--|--|---|
| 1. DECEASED-NAME<br>(Type or Print) <b>REV Herley LEE Long</b>   |                  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>7</b> Day <b>12</b> Year <b>1968</b> |   |  | 2b. HOUR <b>9:30</b> AM  |  |   |
| 3. SEX <b>M</b>  | 4. RACE <b>C</b> | 5. DATE OF BIRTH <b>6/29/10</b>         | 6. AGE (In years last birthday) <b>58</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                     | 2c. DATE PRONOUNCED DEAD<br>Month <b>July</b> Day <b>2</b> Year <b>1968</b>                  |  |   |
| 7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH <b>Bandallstown</b>  |                  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. G. Gen. Hosp.</b>  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>  |                  |   | 13b. COUNTY <b>Balto</b>  |   | 13c. CITY OR TOWN <b>-</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>2005 Royal Garden Ct.</b>           |
| 14. FATHER'S NAME <b>Edward Long</b>   |                  |   | 15. MOTHER'S MAIDEN NAME <b>Blanche Sally</b>   |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                  |   | 16b. SOCIAL SECURITY NO. <b>599-12-7070</b>   |   |  | 17. INFORMANT <b>George Long Same</b> ADDRESS  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |                  |   |   |   |  |  |  |   |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b>                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |   |   |  |  |  |   |
| ACTUAL SIGNATURE <b>James N. Frederick</b> M.D.  |                  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  | 22b. DATE SIGNED <b>7/1/68</b>   |  |   |
| EXAMINER'S NAME (Type) <b>James N. Frederick</b>   |                  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  | ADDRESS (Street, city, town, or county) <b>1311 Francis Ave Balto Md. 21227</b>              |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                  | 23b. DATE <b>7-6-68</b>                 |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Ant</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Lanv Md</b>                                 |  |   |
| 24. FUNERAL DIRECTOR <b>Eloyd Wilson 1000 Grant St</b>   |                  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR <b>JUL - 9 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>                |

88333

88333

107 - 8 AMB



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09621   |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 09632   |  |   |  |                                   |  |
|---|--|---|--|--|--|--|--|---|--|---|--|-----------------------------------|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |   |  |                                   |  |
| 1. DECEASED-NAME (Type or print) <i>Wilbur</i>  |  |   |  | First <i>W.</i> Middle <i>W.</i> Last <i>Long</i>  |  |  |  | 2a. DATE OF DEATH <i>July</i> Month <i>20</i> , Day <i>1968</i>   |  |   |  | 2b. HOUR <i>M</i>                 |  |
| 3. SEX <i>Male</i>  |  | 4. RACE <i>White</i>                    |  | 5. DATE OF BIRTH <i>June 4, 1881</i>   |  |  |  | 6. AGE (In years last birthday) <i>87</i> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.   |  |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH <i>Reisterstown</i>   |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Dover Road</i>   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired Farmer</i> |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  |   |  | 13b. COUNTY <i>Balto.</i>  |  | 13c. CITY OR TOWN <i>Reisterstown</i>                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | 13e. STREET AND NUMBER <i>Dover Road</i>                                      |  |                                   |  |
| 14. FATHER'S NAME First <i>Charles</i> Middle <i>Long</i> Last <i>Long</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Dearholt</i> Last <i>Dearholt</i>  |  |  |  |   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)  |  |   |  | 16b. SOCIAL SECURITY NO. <i>215-36-8058</i>  |  | 17. INFORMANT Address <i>Mr. Charles M. Long Towson, Md.</i> |  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>few hrs</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Decomposition</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>few hrs</i><br>(c) <i>Funeral as unknown</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>"</i> |  |   |  |  |  |  |  |   |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>  |  |   |  |  |  |  |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION <i>✓</i>   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>✓</i>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>✓</i> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>✓</i>                      |  |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>✓</i>  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State <i>✓</i>   |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-1-68</i> to <i>7-20-68</i> , that (I) (we) lost saw the deceased alive on <i>7-20-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |   |  |                                   |  |
| 22b. SIGNATURE <i>James G. Saffell</i>  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED <i>7-20-68</i>   |  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) <i>James G. Saffell</i>  |  |   |  | 22e. ADDRESS <i>Reisterstown, Md.</i>  |  |  |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  |   |  | 23b. DATE <i>July , 68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Carroll Chapel</i>     |  |   |  | 23d. LOCATION (City or Town) (County) (State) <i>Lutherville, Md.</i>         |  |                                   |  |
| 24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>  |  |   |  | ADDRESS <i>Reisterstown, Md.</i>   |  |  |  | 25a. REC'D BY REGISTRAR <i>JUL 22 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>                            |  |                                   |  |

1933

INSTITUTE OF DEATH

1933



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                         |  |        |   |  |  |  |   |      |
|---|-------------------------|--|--------|---|--|--|--|---|------|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>HARVEY</b>   | Middle | Last<br><b>LUCAS</b>  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> Month Day Year<br>MATED <input type="checkbox"/> July 29, 1968 |  | 2b. HOUR<br>7:29 AM  |   |      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Nov. 28, 1913</b><br>64/28/16   |        | 6. AGE (In years birthday)<br><b>54</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>July 29, 1968</b> | 2d. HOUR<br>7:29 AM   |      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  | Md.   |      |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore County General Hospital</b> |        |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Construction</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>New Jersey</b>   |                         | 13b. COUNTY<br><b>Pemberton</b>  |        | 13c. CITY OR TOWN<br><b>Pemberton</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 13e. STREET AND NUMBER<br><b>Route 38 S. Pemberton Road</b> |      |
| 14. FATHER'S NAME<br><b>John D. Lucas</b>   |                         | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME<br><b>Della Nixon</b>   |  | First  | Middle  | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |                         | (If yes give war or dates of service)  |        | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Harry Lucas 22 State Court</b>   |  | ADDRESS   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4109</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |  |        |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><b>4201</b>  |                         |  |        |   |  |  |  |   |      |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |      |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |      |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |        |   |  |  |  |   |      |
| ACTUAL SIGNATURE<br><b>Edward F. Wilson, M.D.</b>   |                         | EXAMINER'S NAME (Type)   |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>July 29, 1968</b>   |  |   |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                         | 23b. DATE<br><b>July 30/68</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pemberton Baptist</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pemberton Township New Jersey</b>                          |  |   |      |
| 24. FUNERAL DIRECTOR<br><b>Ulrich Funeral Home, Balto. for Perinchief Chapel, MT. Holly, N.J.</b>   |                         | 25a. REC'D BY REGISTRAR<br><b>AUG 2 1968</b>   |        | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |   |      |

60380

4831

UNITED STATES DEPARTMENT OF JUSTICE



U.S.A.

RECEIVED



OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D.C.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                           |  |  |   |  |  |  |   |   |   |                   |   |                   |
|---|---------------------------|--|--|---|--|--|--|---|---|---|-------------------|---|-------------------|
| <div>09623</div> <div>Item #5, Film G403 8/1</div> <div>09634</div> <h2>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2>  |                           |  |  |   |  |  |  |   |   |   |                   |   |                   |
| 1. DECEASED-NAME<br>(Type or Print)   |                           |  | First<br><b>ELMER</b>  |   |  | Middle<br><b>F:</b>  |  |   | Last<br><b>LYLES</b>                                    |   |                   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 7 23 1968 | 2b. HOUR<br>10:00 |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Colored</b> | 5. DATE OF BIRTH<br><b>Dec 10, 1952</b>  | 6. AGE (In years<br>last birthday)<br><b>16</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>July</b> Day <b>23</b> Year <b>1968</b>                    |   |   | 2d. HOUR<br>10:00 |   |                   |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Md.</b>   |                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>  |  |   |   |   |                   |   |                   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. Randallstown</b>   |                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Balto. Co. General Hosp.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Laborer</b>   |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Trucking</b> |   |                   |   |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>   |                           |  | 13b. COUNTY<br><b>BALTO.</b>   |   |  | 13c. CITY OR TOWN<br><b>Randlestown</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Oakland Park Rd.</b>     |                   |   |                   |
| 14. FATHER'S NAME<br>First <b>George</b> Middle <b>Thomas</b> Last <b>Lyles</b>   |                           |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Nellie</b> Middle <b>Rebecca</b> Last <b>Fisher</b>                           |   |  |  |  |   |   |   |                   |   |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                           |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>   |   |  | 17. INFORMANT<br><b>MRS. Nellie Lyles</b>  |  |   | ADDRESS<br><b>Randallstown, Md.</b>                     |   |                   |   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Laceration of the aorta</b><br><b>8147</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                           |  |  |   |  |  |  |   |   |   |                   |   |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>8124</b>   |                           |  |  |   |  |  |  |   |   |   |                   |   |                   |
| 19a. DATE OF OPERATION  |                           |  |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |   |                   |   |                   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                           |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>? P.M. 7 23 1968</b>                                       |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Subject was running out in the path of cars</b>  |  |   |   |   |                   |   |                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>   |                           | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br><b>Road</b> |  | 21f. LOCATION Street or R.F.D. No.<br><b>Liberty Rd.</b>  |  | City or Town<br><b>Balto.</b>  |  | County<br><b>Balto.</b>   |   | State<br><b>MD.</b>                                   |                   |   |                   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <b>Not a natural cause</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |  |   |  |  |  |   |   |   |                   |   |                   |
| ACTUAL<br>SIGNATURE<br><b>Edward F. Wilson</b><br>EXAMINER'S<br>NAME (Type)   |                           |  | <b>Edward F. Wilson, M.D.</b>  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |   | 22b. DATE SIGNED<br><b>July 24, 1968</b>                |   |                   |   |                   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |                           | 23b. DATE<br><b>7-27-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bushy Park Cemetery</b>  |  | 23d. LOCATION (City or Town)<br><b>Coolsville</b>  |  | County<br><b>Md.</b>  |   | State   |                   |   |                   |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>  |                           |  |  | ADDRESS<br><b>Sykesville, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUL 30 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |                   |   |                   |

8283

8373

1930 10 10 11 52 AM 2 43 PM

101

101

2

11

11

11

11

11

11

11

11

11

11

11 30 1930



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
09624  
CERTIFICATE OF DEATH  
09635

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                       |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>2012 Westchester Ave. Catonsville, Md.</b>                          |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>2012 Westchester Ave.</b>  |                                  | d. STREET ADDRESS<br><b>2012 Westchester Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Millard</b> Middle <b>E.</b> Last <b>Mace</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1968</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 30, 1885</b> |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Balto. Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>Philmore Mace</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Florence Allen</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213-16-6175</b>  |   |
| 17. INFORMANT<br><b>Mrs. Mable M. Mace</b>  |                                  | Address <b>Md. 2012 Westchester Ave.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>4109 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO (c) <b>ARTERIOSCLEROSIS</b><br>5 MOS.<br>10 YRS. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HR.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>4201 <b>EMPHYSEMA.</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>MAR 8, 1966</b> to <b>JULY 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>JUNE 17, 1968</b> and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.   |                                  |  |   |
| 22a. SIGNATURE<br><b>John N. Snyder</b> M.D.  |                                  | 22b. DATE SIGNED<br><b>7/24/68</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN N. SNYDER M.D.</b>  |                                  | 22d. ADDRESS<br><b>6348 FREDERICK RD CATONSVILLE MD.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>July 26, 1968</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorriane Park Cem.</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Woodlawn, Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 25 1968</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |  |   |

00000

00000

VI

Wato.

Wato.

2012 Washington Ave. Cantonville, Mo.

Cantonville

2012 Washington Ave.

2012 Washington Ave.

Wato.

Wato.

March 30, 1968

Wato.

Wato.

U. S. A.

Wato.

Wato.

Wato.

Wato.

Cantonville, Mo.

Wato.

Wato.

Wato.

Wato.

Wato.

Wato.

Wato.

Wato.

Wato.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |   |  |                          |  |   |  |
|--|--|---|--|--|--|---|--|--------------------------|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |   |  |                          |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |                          |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First   |  | Middle   |  | Last  |  | 2a. DATE OF DEATH        |  | 2b. HOUR  |  |
| Mary   |  | Theresa   |  | Mangione   |  |   |  | Month 7 Day 22 Year 68   |  | 50A   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (In years<br>lost birthday)  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.                                |  |
| Female   |  | Caucasian   |  | 9/10/1894  |  | 73 YRS.   |  | MONTHS                   |  | DAYS  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                          |  |   |  |
| Italy  |  | U.S.A.  |  |  |  | Baltimore   |  |                          |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |                          |  |   |  |
| Towson   |  | Great. Balt. Med. Cen.  |  | Retired  |  | 21093   |  |                          |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admitted to hospital)  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |   |  |
| Maryland   |  | Baltimore   |  | Lutherville  |  |   |  | 28 Cavan Drive           |  | 21093   |  |
| 14. FATHER'S NAME  |  | First   |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                               |  |
| Vincent  |  | Carbone   |  |  |  |   |  | Margaret                 |  | Pistorio  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | Address   |  |                          |  |   |  |
| N  |  | 217-16-5792   |  | 2 Patients chart 6701 N. Charles St.   |  |   |  |                          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Edema and Cardiac arrest<br>2509 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sympathectomy for Gangrene Toe<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. DUE TO, OR AS A CONSEQUENCE OF<br>(c) Diabetic and Gangrene Toe |  |   |  |  |  |   |  |                          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>260x   |  |   |  |  |  |   |  |                          |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                          |  |   |  |
| 7/11/68  |  | Gangrene toe (left leg)   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |                          |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                          |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                          |  |   |  |
|  |  |   |  |  |  |   |  |                          |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 7/21, 1968, to 7/22, 1968, that (X) (we) last<br>saw the deceased alive on 7/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (X) (we) (did not) view the body after death.  |  |   |  |  |  |   |  |                          |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS  |  |                          |  |   |  |
| Dr. Naeim  |  | 7/22/68   |  | Faramaza Naeim   |  | 6701 N. Charles Street  |  |                          |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                          |  |   |  |
| Burial   |  | July 25, 1968   |  | Dulaney Valley Memorial  |  | Packerville, Md.  |  |                          |  |   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                          |  |   |  |
| John Buas  |  | JUL 29 1968   |  | Charles Judge  |  |   |  |                          |  |   |  |

40020

10/25/64

83002



66

10-10-64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>09626</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>09637</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Item#5, FilmG402 7/17/68 km</span> <span>CERTIFICATE OF DEATH</span> </div>   |  |  |  |   |  |   |   |  |   |       |  |
|---|--|--|--|---|--|---|---|--|---|-------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Annie C. Manser</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>7 Month 12 Day 68 Year   |   |  | 2b. HOUR a<br>10:20 M                                 |       |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>7-18-96/ 1895</b>  |  |   | 6. AGE (In years lost birthday)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                        |       | IF UNDER 24 HRS.<br>HOURS MIN.               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |   |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>         |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>            |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2905 Erie Ave. 21234</b> |       |  |
| 14. FATHER'S NAME First Middle Last<br><b>John F. Bracken</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Margaret Gately</b>  |  |   |   |  |   |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-23-8431</b>   |   | 17. INFORMANT Address<br><b>Hospital Records</b> |   |   |  |   |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>coronary arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |   |  |   |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |  |   |  |   |   |  |   |       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County   |   | State |  |
| 22a. I certify that (H) (this hospital) attended the deceased from <b>July 3</b> , 19 <b>68</b> , to <b>July 12</b> , 19 <b>68</b> , that (H) (we) last saw the deceased alive on <b>July 12</b> , 19 <b>68</b> , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |   |   |  |   |       |  |
| 22b. SIGNATURE<br><br>DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |   |  |   |   | 22c. DATE SIGNED<br><b>7-12-68</b>                                   |   |       |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lawrence Misanik, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>7620 York Rd. Towson, Md. 21204</b>  |  |   |   |  |   |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/15/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |   |       |  |
| 24. FUNERAL DIRECTOR<br><b>C.F. EVANS &amp; SON 8802 Harford Rd.</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 15 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |   |  |   |       |  |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09638

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>Lillian</i>   |  | First <i>E.</i>  |  | Middle <i>Marken</i>   |  | Last   |  | 2a. DATE KNOWN OF DEATH<br>MATED <input checked="" type="checkbox"/> <i>July 31</i> 19 <i>68</i> |  | 2b. HOUR <i>5P</i> M.                          |  |
| 3. SEX <i>Female</i>   |  | 4. RACE <i>White</i>   |  | 5. DATE OF BIRTH <i>Nov. 16, 1915</i>  |  | 6. AGE (In years last birthday) <i>52</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>   |  | IF UNDER 24 HRS.<br>HOURS <i></i> MIN. <i></i> |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH <i>Baltimore</i>  |  |  |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH <i>Towson</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph's Hosp.</i>   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Housewife</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |  | 13b. COUNTY <i>Baltimore</i>   |  | 13c. CITY OR TOWN <i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <i>3220 Texas Avenue</i>  |  |  |  |
| 14. FATHER'S NAME<br>First <i>James</i> Middle <i></i> Last <i>Wagner</i>  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Alice</i> Middle <i>O'Rourke</i> Last <i>O'Rourke</i>   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>217-09-8963</i>  |  | 17. INFORMANT <i>Mr. Jack G. Marken, Sr.</i>   |  | ADDRESS (Same)   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>4120</i><br>(b) <i>Myocardial Infarction - 2+ yrs</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Chronic Vascular Disease</i>  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><i>442X</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 yrs</i>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <i>19</i> P.M. <i></i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. DATE SIGNED <i>7/31/68</i>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 23b. DATE <i>8/3/68.</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Fork Methodist Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State) <i>Fork, Md.</i>                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>   |  | ADDRESS  |  | 25a. BY REGISTRATION <i>AUG 1 1968</i>   |  | 25b. BY PAR'S SIGNATURE <i>Peter J. Judge</i>  |  |  |  |  |  |

1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09628

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09639

# CERTIFICATE OF DEATH

|  |                              |  |   |   |                                 |  |   |  |          |
|--|------------------------------|--|---|---|---------------------------------|--|---|--|----------|
| 1. DECEASED-NAME<br>(Type or print)  |                              | First  | Middle  | Last  | 2a. DATE OF DEATH               |  | 2b. HOUR                                  |  |          |
| Charles  |                              | W.   |   | MARSHALL Jr.  | Month Day Year<br>July 29, 1968 |  | 11:30 AM                                  |  |          |
| 3. SEX   | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |          |
| Male   | White                        |  | December 14, 1955   |   | 12 YRS.                         |  |   |  |          |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH              |  | Md.                                       |  |          |
| Virginia   | U.S.A.                       |  |   |   | Baltimore,                      |  |   |  |          |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |          |
| Towson   |                              | ST. JOSEPH HOSPITAL  |   | Student   |                                 |  |   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER                       |          |
| Maryland   |                              | Baltimore  |   | Baltimore   |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 21234<br>9631 Oak Summit Ave.                |          |
| 14. FATHER'S NAME  |                              | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME        |  | First                                     | Middle                                       | Last     |
| Charles  |                              | W.   |   | Marshall Sr   | Ruth                            |  | E.  |  | Greasman |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |                                 | Address  |   |  |          |
| No   |                              | None   |   | Mr Charles W. Marshall Sr.  |                                 | 9631 Oak Summit A  |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>7331<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Muscular dystrophy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                              |  |   |   |                                 |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br>7441  |                              |  |   |   |                                 |  |   |  |          |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |          |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                                 |  |   |  |          |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                 |  |   |  |          |
| 22a. I certify that (X) (this hospital) attended the deceased from 7/26/1968, to 7/29/1968, that (X) (we) last saw the deceased alive on 7/29/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                              |  |   |   |                                 |  |   |  |          |
| 22b. SIGNATURE<br>Imelda B. Salanio  |                              |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                 | 22c. DATE SIGNED<br>July 29, 1968  |   |  |          |
| 22d. PHYSICIAN'S NAME (Type)<br>Imelda B. Salanio, M.D.  |                              |  |   | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |                                 |  |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town) (County) (State)  |   |  |          |
| Burial   |                              | 8-1-1968   |   | Gardens of Faith Cemetery   |                                 | Baltimore Co. Md   |   |  |          |
| 24. FUNERAL DIRECTOR<br>Sassah 7401 Belair Rd.   |                              |  |   | 25a. REC'D BY REGISTRAR<br>AUG 1 1968   |                                 | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |   |  |          |

85322

2.2

Abstract

2000

Fullerton 2011 Cal Street Ave.

1997

100

U. S. Copyright Office, U. S. Dept. of Commerce.

8591

631A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or print) <b>MATTHEWS (BABY GIRL)</b>  |  |  |  |   | 2a. DATE OF DEATH<br>Month <b>7</b> Day <b>29</b> Year <b>68</b>                     |   | 2b. HOUR<br><b>7:05</b> M  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>7/25/68</b>  |  | 6. AGE (In years lost birthday)<br><b>YRS.</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b>3</b> DAYS <b>3</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO., MD.</b>  |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE MD.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO., MED. CENTER</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>  |  | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6002 St Regis Rd</b> |  |
| 14. FATHER'S NAME<br>First <b>Jeffrey</b> Middle <b>Matthews</b> Last <b>Matthews</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>Ann</b> Last <b>Maroney</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Jeffrey Matthews</b>  |  | Address <b>Same</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY DISTRESS SYNDROME</b><br><b>776.2</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYALINE MEMBRANE, BILATERAL PNEUMOTHORAX</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROBABLE PNEUMONIA</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>763.0</b>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>7/25</b> , 19 <b>68</b> , to <b>7/29</b> , 19 <b>68</b> , that (I) <del>two</del> <b>one</b> sowed the deceased alive on <b>7/29</b> , 19 <b>68</b> , and that in (my) <del>our</del> <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <b>did not</b> view the body after death.                             |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>W. De Voe</b>   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>7/29/68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. William F. DeVoe M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>6701 N. Charles St. 21204</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/30/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc Baltimore, Md.</b>   |  |  |  | 25a. RECEIVED BY REGISTRAR<br>DATE <b>JUL 30 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

1333

(二、三、四、五)

THE UNIVERSITY OF CHICAGO

O'LOUGHEE, JAMES, JR., BORN 1870, DIED 1960.

100

1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
09630  
09641  
CERTIFICATE OF DEATH

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>m Baltimore County</i> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> b. COUNTY<br><i>Baltimore</i>          |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Timonium</i>  |                                  | c. LENGTH OF STAY IN 1b<br><i>Timonium</i>  |   |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Timonium</i>  |                                  | d. STREET ADDRESS<br><i>2103 Reuter Road</i>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>2103 Reuter Road</i>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Wilhamena</i> Middle <i>A</i> Last <i>Matthews</i>   |                                  | 4. DATE OF DEATH<br>Month <i>July</i> Day <i>27</i> Year <i>1968</i>  |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Sept. 12, 1913</i> |
| 9. AGE (in years last birthday)<br><i>54</i> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <i>54</i> Days <i>54</i> Hours <i>54</i> Min. <i>54</i>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>own home</i>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 13. FATHER'S NAME<br><i>Otto Stehn</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Myrtle Frey</i>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>no</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |   |
| 17. INFORMANT<br><i>Family records</i>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma Breast Lt &amp; generalized metastasis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>174X |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 yrs</i>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>170X  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1965</i> , to <i>July, 1968</i> , that (I) (we) last saw the deceased alive on <i>27 July 1968</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><i>Harold A. Brene</i>   |                                  | 22b. DATE SIGNED<br><i>29 July 68</i>   |   |
| 22c. PHYSICIAN'S NAME (Type)   |                                  | 22d. ADDRESS<br><i>1202 St Paul St Baltimore Md 21202</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 23b. DATE THEREOF<br><i>7/30/68</i>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cemetery</i>  |                                  | 23d. LOCATION (City, town or county) (State)<br><i>Baltimore Md.</i>  |   |
| 24. FUNERAL DIRECTOR<br><i>John Burns Sons</i>   |                                  | 25a. REC'D BY REGISTRAR<br><i>JUL 31 1968</i>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                  |   |   |

| NAME       | SEX  | AGE | RACE  | RELATION | DATE OF BIRTH | PLACE OF BIRTH | DATE OF DEATH | PLACE OF DEATH | CAUSE OF DEATH |
|------------|------|-----|-------|----------|---------------|----------------|---------------|----------------|----------------|
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |
| John Jones | Male | 25  | White | Wife     | 1913          | Illinois       | 1913          | Illinois       | Illness        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |                              |
|--|--|--|--|---|--|---|--|--|------------------------------|
| 09631 CERTIFICATE OF DEATH 09642   |  |  |  |   |  |   |  |  |                              |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                     |
| Geraldine Selma Mc Callister   |  |  |  |   |  | 7 Month 20 Day 68 Year  |  |  | 9 a M                        |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                              |
| Female   |  | Caucasian  |  | 9/12/20   |  | 47 YRS.   |  |  |                              |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                              |
| Maryland   |  | U.S.A.   |  |   |  | Baltimore Md.   |  |  |                              |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                              |
| Towson   |  |  | Great. Balt. Med. Cen.   |   |  | Housewife   |  |  |                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER       |
| Maryland   |  |  | BALTO  |   | Parkville  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 21234<br>8123 Clyde Bank Rd. |
| 14. FATHER'S NAME  |  |  | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  |  | First Middle Last            |
| Gerald Wilson Flahaven   |  |  |  |   |  | Edith Theresa Johnson   |  |  |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   |  |  | Address                      |
|  |  |  | 215-14-4779  |   | Patient's Chart 6701 N. Charles St.  |   |  |  | 21204                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u><br><u>180X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Anemia, @nd 2nd to Bmey Marrow Depletion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma of the Cervix, Lft&amp;Rgt 4</u> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Days</u><br><u>6 Days</u><br><u>Dec. 1967</u> |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>171X</u>  |  |  |  |   |  |   |  |  |                              |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)      |   |  |  |                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |  |                              |
| 22a. I certify that (this hospital) attended the deceased from <u>June 25</u> , 19 <u>68</u> , to <u>July 20</u> , 19 <u>68</u> , that (he) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>68</u> , and that in (our) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |                              |
| 22b. SIGNATURE<br><u>Lillian Lim Liao</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>July 20, 1968</u>   |                              |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Dr. Lillian Lim Liao M.D.</u>   |  |  |  |   |  | 22e. ADDRESS<br><u>6701 N. Charles St. 21204</u>  |  |  |                              |
| 23a. BURIAL, CREMATION, or other disposition (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                              |
| Burial   |  | 7/22/68  |  | Moreland Memorial Park  |  | Baltimore, Maryland   |  |  |                              |
| 24. FUNERAL DIRECTOR<br><u>Leonard J Ruck Inc. Baltimore, Maryland</u>   |  |  |  |   |  | 25a. RECD BY REGISTRAR<br><u>Jul 22 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                              |

15:00

328 李 明

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if cremation, within 12 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Eva</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>24</b> Year <b>1968</b>                |  | 2b. HOUR<br><b>7:07</b> M   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>November 1, 1874</b>   |  | 6. AGE (In years last birthday)<br><b>93</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.                                    |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove State Hospital</b>  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Prince Georges</b>  |  | 13c. CITY OR TOWN<br><b>Mt. Rainier</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 13e. STREET AND NUMBER<br><b>4503 - 30th Street</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Joseph T. Lowry</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sydnor, Gertrude S.</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Records: Spring Grove State Hospital</b>                 |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute, death</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Dis.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b><br>(b) <b>Arteriosclerotic, Cardiovascular Heart</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerosis, Generalized, senile</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mins.</b><br><b>20 yrs.</b><br><b>20 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Pulmonary Emphysema with Chronic Obstructive Airway Disease.</b>   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |   |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>August 9, 1945</b> , to <b>July 24, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 24, 1968</b> , and that in (my) ( <del>our</del> ) apinian death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <b>did not</b> ) view the body after death.   |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Anthony J. Young</i>   |  |  |  | 22c. DATE SIGNED<br><b>7-25-68</b>  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |  |   |  |
| 22e. ADDRESS<br><b>Spring Grove State Hospital<br/>Baltimore, Maryland 21228</b>  |  |  |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>7/28/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENMOUNT Cem</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BAL To. Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>E. S. MacNabb</b>  |  |  |  | ADDRESS<br><b>Catonsville Md</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 29 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

535

159

馬 永 寶

•

10. *Journal of the American Medical Association*, 277:1033-1034, 1996

DATE: 2/2/2004

Journal of Management Education 32(10)

Anthony J. Young, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1

09633

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09644

CERTIFICATE OF DEATH

|  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>DAVE</b>  |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH<br>Month <b>JULY</b> Day <b>6</b> Year <b>1968</b>  |  |  | 2b. HOUR<br><b>9.10 P.M.</b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>NEGRO</b>   |  |  | 5. DATE OF BIRTH<br><b>5-11-1915</b>  |  |  | 6. AGE (In years last birthday)<br><b>53</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>S.C.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County,</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Wilson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br><b>JAMES</b>  |  |  | First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>JULIA</b>  |  |  | First Middle Last<br><b>BELTON</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>250-28-5207</b>  |  |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Squamous Cell Ca of the Lung</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>163X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>Pulm T.B. active</b>   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-20-</b> , <b>1968</b> , to <b>7-6</b> , <b>1968</b> , that (I) (we) last saw the deceased alive on <b>7-6-68</b> , <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  |  |   |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>7-6-68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>7-10-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bonnesville Bapt. Cem.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Sumpters, N.C.</b>                       |  |  |
| 24. FUNERAL DIRECTOR<br><b>Rev. D. Nelson</b>  |  |  |   |  |  | ADDRESS<br><b>Funeral Home 1348 N. Calhoun St.</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1968</b>  |  |  |
|  |  |  |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

03044

CHICAGO, ILL.

11714

Chicago, Ill.

St. John's, N.Y.

St. John's, N.Y.

St. John's, N.Y.

St. John's, N.Y.

St. John's, N.Y.

St. John's, N.Y.

CERTIFICATE OF DEATH

09634

09645

|  |  |  |                          |   |  |   |  |  |
|--|--|--|--------------------------|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Cora</b>   |  | First<br><b>G.</b>   | Middle<br><b>McGinn</b>  | Last  | 2a. DATE OF DEATH<br><b>July</b> Month <b>20</b> Day <b>1968</b> Year                |   | 2b. HOUR<br><b>1:45</b> P.M.   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |                          | 5. DATE OF BIRTH<br><b>10-9-10</b>  |  | 6. AGE (In years lost birthday)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |
| 1d. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |                          | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>1310 E. Belvedere Ave</b><br><b>21212</b> |
| 14. FATHER'S NAME<br><b>Harry J. Larkins</b>   |  | First<br><b>Harry J.</b>   | Middle<br><b>Larkins</b> | Last  | 15. MOTHER'S MAIDEN NAME<br><b>Esther Warner</b>                                     |   | First<br><b>Esther</b>   | Last<br><b>Warner</b>  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-4545</b>   |                          | 17. INFORMANT<br><b>Robert J. McGinn</b>  |  | Address<br><b>Same</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>582X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>593X</b><br>(b) <b>Chronic renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                          |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Myocardial infarction</b>  |  |  |                          |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-29</b> , 19 <b>68</b> , to <b>7-20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-20-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |                          |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Lorna G. Gaudiel, M.D.</b>  |  |  |                          | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-20-68</b>                                     |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lorna G. Gaudiel, M.D.</b>  |  |  |                          | 22e. ADDRESS<br><b>7620 York Road, Towson, Maryland 21204</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-24-68</b>  |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville Balto. Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |  |  |                          | ADDRESS<br><b>4905 York Rd., Balto.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JL 22 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

522

27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09635

09646

|  |  |   |  |   |  |   |  |  |   |
|--|--|---|--|---|--|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Leonard F McGreevy</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>1</b> Year <b>1968</b>       |   |  | 2b. HOUR<br><b>1:50 PM</b>  |  |  |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>October 26, 1882</b>   |  | 6. AGE (In years<br>lost birthday)<br><b>85</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN         |   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Accountant</b>   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>U.S. Govern-<br/>ment</b>                            |  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2 Virginia Ave.</b> |   |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Archibald H. McGreevy</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mary Emily Frailey</b> |   |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-3737</b>  |  | 17. INFORMANT<br>Address<br><b>Mary Lane 2 Virginia Ave</b>   |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Pulmonary Thrombo Embolism</b><br><b>185X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                     |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>177X</b>   |  |   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>June 24, 1968</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of prostate?</b>                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 18, 1968</b> , to <b>July 1, 1968</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>July 1, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Dr. Christina Feliciano, M.D.</b>   |  |   |  | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                |  | 22c. DATE SIGNED<br><b>July 1, 1968</b>   |  |  |   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Dr. Christina Feliciano</b>  |  |   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |   |  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 5, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Dipfel Bros Inc. 7110 Belair Rd</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL - 5 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |  |   |

4230



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |   |   |                                    |  |  |   |   |  |
|--|--|------------------------------|---|---|------------------------------------|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |   |   |                                    |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |                              |   |   |                                    |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First Middle Lost   |   |                                    | 2a. DATE OF DEATH  |  | 2b. HOUR  |   |  |
| Baby Girl  |  |                              | McKenna   |   |                                    | July Month 5 Day 1968  |  | 9:42 A M  |   |  |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH  |                                    | 6. AGE (in years<br>lost birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   |  |
| Female   |  | White                        |   | 7-5-68  |                                    | YRS.   |  | 10  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |   |   |  |
| Baltimore  |  | USA                          |   |   |                                    | Baltimore Md.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |   |  |
| Baltimore  |  |                              | St. Joseph Hospital   |   |                                    |  |  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE  |  |                              | 13b. COUNTY   |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET AND NUMBER                          |  |
| Maryland   |  |                              |   |   | Baltimore                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 2002 Wilkins Avenue 21223                       |  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME  |   |                                    |  |  |   |   |  |
| Gerard T McKenna   |  |                              | Lynnette C. Bolton  |   |                                    |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT                      |  |  |   |   |  |
| No   |  |                              | ---   |   | Mother Address                     |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |   |   |                                    |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) - Prematurity  |  |                              |   |   |                                    |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |   |   |                                    |  |  |   |   |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |  |                              |   |   |                                    |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |   |   |                                    |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)  |  |                              |   |   |                                    |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
|  |  |                              |   |   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY   |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |  |   |   |  |
|  |  |                              | HOUR A.M. Month Day Year<br>P.M. 19   |   |                                    |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                               |  |   |   |  |
|  |  |                              |   |   |                                    |  |  |   |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 7-5, 1968, to 7-5-68, 19__, that (X) (we) last<br>saw the deceased alive on 7-5-1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |   |   |                                    |  |  |   |   |  |
| 22b. SIGNATURE   |  |                              |   |   | DEGREE                             |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |                              |   |   | 7620 York Road, Towson, Md. 21204  |  |  |   | 7-6-68  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |                              | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION (City or Town) (County) (State)  |   |   |  |
| Burial   |  |                              | 7/8/1968  |   | Holy Redeemer Cemetery             |  | Baltimore, Md.   |   |   |  |
| 24. FUNERAL DIRECTOR   |  |                              |   |   | 25a. REC'D BY REGISTRAR            |  | 25b. REGISTRAR'S SIGNATURE   |   |   |  |
| Eugenia K. Seitz 5209 York Rd<br>Baltimore, Md. 21212  |  |                              |   |   | JUL 11 1968                        |  | J Charles Judge  |   |   |  |

72880

WILSON

82731



RECEIVED JUL 11 1961

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |                   |  |  |  |
|---|--|--|--|--|--|--|--|--|-------------------|--|--|--|
| Item #10, 11, Film G402 <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> 08648  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 1. DECEASED-NAME (Type or Print) <i>Charles E. McKenna</i>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>July</i> <input type="checkbox"/> Day <i>4</i> <input type="checkbox"/> Year <i>1968</i>       |  |  | 2b. HOUR <i>M</i> |  |  |  |
| 3. SEX <i>Male</i>  |  | 4. RACE <i>White</i>   |  | 5. DATE OF BIRTH <i>Oct. 8, 1924</i>   |  | 6. AGE (In years last birthday) <i>43</i> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>   |                   | IF UNDER 24 HRS.<br>HOURS <i></i> MIN. <i></i>   |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore</i>  |                   |  | 2c. DATE PRONOUNCED DEAD<br>Month <i></i> Day <i></i> Year <i>19</i> |  |
| 1d. CITY OR TOWN OF DEATH <i>Hampstead, Md.</i>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Piney Branch Golf Course</i> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Book binder</i> |                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  |  |  | 13b. COUNTY <i>Baltimore</i>   |  | 13c. CITY OR TOWN <i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |                   | 13e. STREET AND NUMBER <i>913 Bonaparte Ave.</i> |  |  |
| 14. FATHER'S NAME First <i>Edward</i> Middle <i>McKenna</i> Last <i>McKenna</i>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <i>Emma</i> Middle <i>Hudgins</i> Last <i></i>  |  |  |                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>   |  |  |  | 16b. SOCIAL SECURITY NO. <i>217-12-9015</i>  |  | 17. INFORMANT ADDRESS <i>Leona Singleton, 913 Bonaparte, Ave. Balto.</i>   |  |  |                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Thc.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 mo</i>  |  |  |  |  |  |  |  |  |                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>0021</i> <i>Tuberculosis</i>   |  |  |  |  |  |  |  |  |                   |  |  |  |
| 19a. DATE OF OPERATION <i>None</i>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>  |  |  |  | 2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |                   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>None</i>  |  |  |  | 21b. TIME OF INJURY Month, Day, Year <i>None</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>  |  |  |                   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>None</i> |  |  |  | 21f. LOCATION Street or R.F.D. No. <i></i>   |  | City or Town <i></i>   |                   | County <i></i> State <i></i>                     |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |                   |  |  |  |
| ACTUAL SIGNATURE <i>D. D. Caples</i>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <i>7/4/68</i>   |                   |  |  |  |
| EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                   |  |  |  |
|   |  |  |  | ADDRESS (Street, city, town, or county) <i></i>  |  |  |  |  |                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 23b. DATE <i>July 8, 1968</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Gardens</i>  |  | 23d. LOCATION (City or Town) <i>Baltimore, Md.</i>   |  | County <i></i>   |                   | State <i></i>                                    |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <i>Burgee Funeral Home, 3631 Falls Rd. Baltimore</i>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR <i>JUL 10 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>   |                   |  |  |  |

8338

RECEIVED

2003

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |   |  |  |
|--|--|--|--|---|---|---|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>09638</span> <span>CERTIFICATE OF DEATH</span> <span>09649</span> </div>  |  |  |  |   |   |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Leo</b>   |  |  |  |   | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>25</b> Year <b>1968</b>     |   | 2b. HOUR<br><b>2:15</b> <sup>PM</sup>  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>April 6, 1902</b>  |   | 6. AGE (In years last birthday)<br><b>66</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>        |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. City</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>213 Chatsworth Ave.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Printer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Reisterstown</b>                                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>213 Chatsworth Ave.</b>                             |  |
| 14. FATHER'S NAME<br>First <b>Milton</b> Middle <b></b> Last <b>McManus</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Margaret</b> Middle <b></b> Last <b>Lindsey</b>                       |   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (a), or (unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-8212</b>   |   | 17. INFORMANT<br>Address <b>Mrs. Marie D. McManus Reisterstown, Md.</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis - acute</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>2 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4341</b>   |  |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-2</b> , 19 <b>66</b> , to <b>7-25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Clarence E. Williams M.D.</b>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>7-26-68</b>  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>11909 Reisterstown Rd Reisterstown Md.</b>  |  |  |  |   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>July 29, 68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Memorial</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Carroll Co. Md.</b>                                   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons Reisterstown, Md.</b>  |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 29 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |  |  |

0300

RECEIVED

0300

10





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |                                    |   |   |                                |   |  |          |  |
|---|---------|--|--|---|------------------------------------|---|---|--------------------------------|---|--|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |   |                                    |   |   |                                |   |  |          |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First  |   | Middle                             |   | Last  |                                | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR |  |
| Frank   |         |  |  |   |                                    |   | Mekolon                                       |                                | Month Day Year<br>July 27 1968                                      |  | M        |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                    | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD       |   | 2d. HOUR                                     |          |  |
| Male  | White   | 9-13-1904  | 63 YRS.  |   |                                    |   |   | Month Day Year<br>July 27 1968 |   | M  |          |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |                                    | 9. COUNTY OF DEATH  |   |                                |   |  |          |  |
| Maryland  |         | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                    | Baltimore   |   |                                |   | Md.  |          |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| Dundalk   |         |  | 7114 Sollers Point Road  |   |                                    | Carpenter   |   |                                | Contracting   |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |   |                                    | 13c. CITY OR TOWN   |   |                                | 13d. INSIDE CITY LIMITS?  |  |          |  |
| Md.   |         |  | Balto.   |   |                                    | Dundalk   |   |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |
| 13e. STREET AND NUMBER  |         |  | 14. FATHER'S NAME  |   |                                    | 15. MOTHER'S MAIDEN NAME  |   |                                |   |  |          |  |
| 7114 Sollers Pt. Rd.  |         |  | First Middle Last<br>Jacob Mekolon   |   |                                    | First Middle Last<br>Mary Brodowski   |   |                                |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT   |   |                                | ADDRESS   |  |          |  |
| NO  |         |  | 218-01-0552  |   |                                    | Daughter, Mrs. Marcella Danielak  |   |                                | 4506 Bayonne Ave. Balto. Md. 21206                                  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |                                    |   |   |                                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>White Gouty Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Alcoholism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |  |   |                                    |   |   |                                |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |         |  |  |   |                                    |   |   |                                |   |  |          |  |
| 3221  |         |  |  |   |                                    |   |   |                                |   |  |          |  |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |                                    |   |   |                                | 20. AUTOPSY?  |  |          |  |
|   |         |  |  |   |                                    |   |   |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                       |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |   |                                |   |  |          |  |
| CAUSE OF DEATH  |         |  | 19   |   |                                    |   |   |                                |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No. |   |   | City or Town                   |   | County State                                 |          |  |
|   |         |  |  |   |                                    |   |   |                                |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |                                    |   |   |                                |   |  |          |  |
| ACTUAL SIGNATURE  |         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |   |                                    | 22b. DATE SIGNED  |   |                                |   |  |          |  |
| EXAMINER'S NAME (Type)  |         |  | Theodore C. Patterson M.D.   |   |                                    | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                           |   |                                | 7-29-68   |  |          |  |
|   |         |  | 3724 Dundalk Ave.  |   |                                    | ADDRESS (Street, city, town, or county)   |   |                                | Dundalk, Md. 21222  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                    |   | 23d. LOCATION (City or Town) (County) (State) |                                |   |  |          |  |
| Burial  |         | 7-30-68  |  | Christ Lutheran   |                                    |   | German Hill Rd. Dundalk, Md.                  |                                |   |  |          |  |
| 24. FUNERAL DIRECTOR  |         |  |  |   |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE     |   |  |          |  |
| John J. Duda, Dundalk, Maryland 21222   |         |  |  |   |                                    | DATE AUG 1 1968   |   | Charles Judge                  |   |  |          |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09640

09651

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |                      |                      |  |  |  |  |   |      |  |  |  |  |  |  |  |  |  |  |
|--|--|----------------------|----------------------|--|--|--|--|---|------|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>James</b>   |  |                      | First <b>Kenneth</b> |  |  | Middle <b>Melton</b>   |  |   | Last |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>July 1, 1968</b>  |  |  |  | 2b. HOUR <input type="checkbox"/> <b>9</b> <input type="checkbox"/> <b>12</b> <input type="checkbox"/> <b>M</b>  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |                      | 5. DATE OF BIRTH <b>Jan. 17, 1937</b>  |  | 6. AGE (In years last birthday) <b>31</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  |      | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>             |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>July 1,</b> Year <b>1968</b>  |  |  |  | 2d. HOUR <input type="checkbox"/> <b>11</b> <input type="checkbox"/> <b>12</b> <input type="checkbox"/> <b>M</b> |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |                      |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  |  |  | Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>   |  |                      |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7007 Fait Ave.</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Machinist</b>  |      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>   |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |                      |                      | 13b. COUNTY <b>Baltimore</b>   |  |  |  | 13c. CITY OR TOWN <b>Dundalk</b>  |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>7007 Fait Ave.</b>   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <b>Elmer D. Melton</b>   |  |                      |                      |  |  | Middle <b>Melton</b>   |  |   |      |  |  | Last <b>Melton</b>   |  |  |  |  |  |  |  |
| 15. MOTHER'S MAIDEN NAME First <b>Julietta</b>   |  |                      |                      |  |  | Middle <b>Ryan</b>   |  |   |      |  |  | Last <b>Ryan</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |                      |                      | (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO. <b>215-34-8804</b>   |      |  |  | 17. INFORMANT ADDRESS <b>Mrs. Barbara Melton 1921 Codd Ave.</b>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sub-Aortic Stenosis</b><br><b>747.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>(Congenital) ?</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |                      |                      |  |  |  |  |   |      |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>7545</b>  |  |                      |                      |  |  |  |  |   |      |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |      |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |                      |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b> |  |   |      |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |                      |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  |   |      |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |                      |  |  |  |  |   |      |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>M.B. Davis</b>   |  |                      |                      |  |  | M.D.   |  |   |      |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>6300 MARLINGTON</b><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>7/2/68</b><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>7/2/68</b><br>22b. DATE SIGNED |  |  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>M.B. Davis, M.D.</b>   |  |                      |                      |  |  | ADDRESS (Street, city, town, or county) <b>Dundalk, Md.</b>  |  |   |      |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                      |                      |  |  | 23b. DATE <b>7/5/68</b>  |  |   |      |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>   |  |  |  |  |  |  |  |
| 23d. LOCATION (City or Town) <b>Overlea, Md.</b>   |  |                      |                      |  |  | (County) <b></b>   |  |   |      |  |  | (State) <b></b>  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home Dundalk, Md.</b>  |  |                      |                      |  |  |  |  |   |      |  |  | 25a. REC'D BY REGISTRAR <b>JUL - 5 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b> |  |  |  |  |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09641

09652

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
|--|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|--|--------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH   |  | Month                    |  | Day   |  | Year   |  | 2b. HOUR                                     |  |
| JOE  |         |  |  |   |  | MELTON  |  | <input checked="" type="checkbox"/> 2   |  | July                     |  | 15,   |  | 1968   |  | 2:05 p.m.                                    |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  | Month   |  | Day    |  | Year   |  |
| male   | white   | 3-28-1913  |  | 55 YRS.   |  | MONTHS  |  | DAYS  |  | July                     |  | 15,   |  | 1968   |  | 2:05 p.m.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH  |  |                          |  |   |  |        |  |  |  |
| North Carolina   |         | U.S.A.   |  |   |  |   |  | Baltimore   |  |                          |  |   |  |        |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |   |  |        |  |  |  |
| Towson   |         | St. Joseph's Hospital  |  | Service Station Owner   |  | Petroleum   |  |   |  |                          |  |   |  |        |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |  |                          |  |   |  |        |  |  |  |
| South Carolina   |         | Kershaw  |  | Camden  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1217 Mc Rae Road  |  |                          |  |   |  |        |  |  |  |
| 14. FATHER'S NAME  |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First                    |  | Middle  |  | Last   |  |  |  |
| Dempster Edward Melton   |         |  |  |   |  |   |  | Edna  |  |                          |  |   |  | McRain |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                          |  |   |  |        |  |  |  |
| no   |         | 245-03-5899  |  | Mrs. Melissa Melton   |  | 1217 McRae Road   |  |   |  |                          |  |   |  |        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| IMMEDIATE CAUSE (a) Multiple Injuries  |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| (c)  |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| 816.4  |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |   |  | 20. AUTOPSY?  |  |                          |  |   |  |        |  |  |  |
|  |         |  |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                          |  |   |  |        |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY Month, Day, Year  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |                          |  | Driver  |  |        |  |  |  |
|  |         |  |  | 11:28p. 7/15 19 68  |  |   |  | of auto which went out of control and hit bus                                   |  |                          |  |   |  |        |  |  |  |
| 21d. INJURY OCCURRED   |         |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)            |  |   |  | 21f. LOCATION Street or R.F.D. No.  |  |                          |  | City or Town                                  |  |        |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |  |  | street  |  |   |  |   |  |                          |  | Towson, Maryland                              |  |        |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| ACTUAL SIGNATURE   |         |  |  | Werner U. Spitz, M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                 |  |                          |  | 22b. DATE SIGNED                              |  |        |  |  |  |
|  |         |  |  |   |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |                          |  | 7/16/68                                       |  |        |  |  |  |
| EXAMINER'S NAME (Type)   |         |  |  |   |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                |  |                          |  | ADDRESS (Street, city, town, or county)       |  |        |  |  |  |
|  |         |  |  |   |  |   |  |   |  |                          |  |   |  |        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION (City or Town) (County) (State) |  |        |  |  |  |
| Burial   |         |  |  | 7-18-68   |  |   |  | Quaker Cemetery   |  |                          |  | Camden Kershaw So. Caroli                     |  |        |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR   |  |                          |  | 25b. REGISTRAR'S SIGNATURE                    |  |        |  |  |  |
| Raymond J. Curran  |         |  |  | 817 Scarlett Drive<br>Towson, Maryland 21204  |  |   |  | JUL 18 1968   |  |                          |  | Charles Judge                                 |  |        |  |  |  |



100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |                                   |  |                  |  |
|--|--|--|--|---|--|---|--|--|-----------------------------------|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| 09642 CERTIFICATE OF DEATH 09653   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |  |                  |  |
| EDWARD   |  |  | L. MENTZER   |   |  | July 11 1968  |  |  | 3:30 A                            |  |                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |
| Male   |  | White  |  | Sept. 5, 1912   |  |   | 55 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  | Mo.                               |  |                  |  |
| Maryland   |  | U.S.A.   |  |   |  | Baltimore   |  |  |                                   |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |
| Towson   |  |  | 209 Garden Road  |   |  | Yard master   |  |  | Railroad                          |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |                                   | 13e. STREET AND NUMBER                       |                  |  |
| Maryland   |  |  | Baltimore  |   |  | Towson  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |                                   | 209 Garden Road                              |                  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |   |  |  |                                   |  |                  |  |
| Irvin Mentzer  |  |  |  | Ellen Beever  |  |   |  |  |                                   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address   |  |  |                                   |  |                  |  |
| No   |  |  |  |   |  | Mrs. Thelma Mentzer 209 Garden Road   |  |  |                                   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| IMMEDIATE CAUSE (a) 1538 Uremia  |  |  |  |   |  |   |  |  |                                   | 1 minute                                     |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intoxication  |  |  |  |   |  |   |  |  |                                   | 3 minutes                                    |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| (c)  |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| 1538   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |                  |  |
|  |  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |                                   |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                                   |  |                  |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | HOUR A.M. Month Day Year P.M. 19   |  |   |  |   |  |  |                                   |  |                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                                   |  |                  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January, 1966, to July, 1968, that (I) (we) last saw the deceased alive on July 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |                                   |  |                  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  | ATTENDING PHYS.   |  | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED                             |                  |  |
| E. Elloitt Harris, M.D.  |  |  |  |   |  |   |  |  |                                   | 7/11/68                                      |                  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS  |  |   |  |  |                                   |  |                  |  |
|  |  |  |  | 8100 Harford Road   |  |   |  |  |                                   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State)                        |  |                                   |  |                  |  |
| Burial   |  | 7/13/68  |  | Moreland Memorial   |  |   | Parkville, Md.   |  |                                   |  |                  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |                  |  |
| Ullrich Funeral Home 4210 Belair Road.   |  |  |  |   |  | JUL 15 1968   |  | Charles Judge  |                                   |  |                  |  |

82330

82330

DEPT. OF HEALTH

STATE OF NEW YORK

OFFICE OF THE COMMISSIONER OF HEALTH

ALBANY, N. Y.

JULY 1, 1968

TO THE HONORABLE GOVERNOR

AND THE HONORABLE SENATE

AND THE HONORABLE ASSEMBLY

OF THE STATE OF NEW YORK

IN SENATE

COMMISSIONER OF HEALTH

REPORT ON THE

STATUS OF THE

HEALTH CARE SYSTEM

IN THE STATE OF NEW YORK

FOR THE YEAR 1967

AND THE PROGRESS MADE

IN THE YEAR 1968

TO DATE

ALBANY, N. Y.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |  |                                    |   |   |   |                                   |  |  |
|---|---------|--|--|--|------------------------------------|---|---|---|-----------------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |  |                                    |   |   |   |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First Middle Last  |  |                                    | 2a. DATE KNOWN OF DEATH   |   |   | 2b. HOUR                          |  |  |
| August HARTMAN MILLER   |         |  |  |  |                                    | Month Day Year  |   |   | 24 M                              |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |                                    | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD  |                                   | 2d. HOUR                                     |  |
| M   | W       | October 13 1887  | 80 YRS.  | MONTHS   | DAYS                               | HOURS   | MIN   | Month Day Year  | 6:30 M                            |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |   | Md.                               |  |  |
| MARYLAND  |         | U. S. A.   |  |  |                                    | BALTIMORE   |   |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| CATONSVILLE   |         |  | 6305 MOUNT RIDGE Rd  |  |                                    | Sales Clothing Mkt.   |   |   | Sales                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE   |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER            |  |  |
| 6305 Mt Ridge Rd  |         |  | Barto  |  | CATONSVILLE                        |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 6305 Mt. Ridge Rd.                |  |  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |   |   |                                   |  |  |
| First Middle Last   |         |  | First Middle Last  |  |                                    |   |   |   |                                   |  |  |
| Henry Miller  |         |  | Mary C. Little   |  |                                    |   |   |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                      |   |   | ADDRESS   |                                   |  |  |
| No  |         |  | 217-05-5615  |  | Mrs. August Miller                 |   |   | 6305 Mt. Ridge Rd. Catonsville Md. 21035                            |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |                                    |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY Disease  |         |  |  |  |                                    |   |   |   |                                   |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |                                    |   |   |   |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |  |  |  |                                    |   |   |   |                                   |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |                                    |   |   |   |                                   |  |  |
| (c)   |         |  |  |  |                                    |   |   |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |  |                                    |   |   |   |                                   |  |  |
| 4201  |         |  |  |  |                                    |   |   |   |                                   |  |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   |   | 2D. AUTOPSY?  |                                   |  |  |
|   |         |  |  |  |                                    |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |  | 21b. TIME OF INJURY Month, Day, Year   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |   |                                   |  |  |
|   |         |  | HOUR A.M. P.M. 19  |  |                                    |   |   |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No. |   |   | City or Town  |                                   | County State                                 |  |
|   |         |  |  |  |                                    |   |   |   |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |                                    |   |   |   |                                   |  |  |
| ACTUAL SIGNATURE  |         |  | CHIEF MEDICAL EXAMINER   |  |                                    | ASSISTANT MEDICAL EXAMINER  |   |   | 22b. DATE SIGNED                  |  |  |
| J. Nelson McKay M.D.  |         |  |  |  |                                    |   |   |   | July 20, 1968                     |  |  |
| EXAMINER'S NAME (Type)  |         |  | DEPUTY MEDICAL EXAMINER  |  |                                    | ADDRESS (Street, city, town, or county)   |   |   |                                   |  |  |
| J. NELSON McKay M.D.  |         |  |  |  |                                    |   |   |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                    |   | 23d. LOCATION (City or Town) (County) (State)                       |   |                                   |  |  |
| Burial  |         | July 23-1968   |  | Cathedral Cemetery   |                                    |   | Barto Md.   |   |                                   |  |  |
| 24. FUNERAL DIRECTOR  |         |  | ADDRESS  |  |                                    | 25. REC'D BY REGISTRAR  |   |   | 25b. REGISTRAR'S SIGNATURE        |  |  |
| FARLEY CAVANAUGH FUNERAL HOME   |         |  | 6601 Frederick Ave. Baltimore Md. 21228                                      |  |                                    | JUL 24 1968   |   |   | J. Charles Judge                  |  |  |

03224

03224

100-100000

100-100000

100-100000

100-100000

100-100000

03224

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09644

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09655

|   |  |  |  |        |      |  |     |      |  |  |
|---|--|--|--|--------|------|--|-----|------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle | Lost | 2a. DATE OF DEATH  |     |      | 2b. HOUR   |  |
| Mary Suzanne MILLER   |  |  |  |        |      | Month  | Day | Year | 24   |  |
| 3. SEX  |  |  | 4. RACE  |        |      | 5. DATE OF BIRTH   |     |      | 6. AGE (In years last birthday)                                      |  |
| Female  |  |  | White  |        |      | 10-7-50  |     |      | 17 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        |      | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |     |      | 9. COUNTY OF DEATH   |  |
| Maryland  |  |  | U.S.A.   |        |      | Baltimore  |     |      | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |     |      | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| Owings Mills  |  |  | Rosewood State Hospital  |        |      | Dependent  |     |      | none   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |        |      | 13c. CITY OR TOWN  |     |      | 13d. INSIDE CITY LIMITS?   |  |
| Maryland  |  |  | Baltimore  |        |      | Baltb. 34  |     |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |        |      | 13e. STREET AND NUMBER   |     |      |  |  |
| Herbert John Miller   |  |  | Mary Florence Anna Wilz Widay  |        |      | 2705 Cub Hill Road   |     |      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |        |      | 17. INFORMANT  |     |      | Address  |  |
| no  |  |  | none   |        |      | Rosewood Records, Owings Mills, Maryland   |     |      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |        |      |  |     |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |        |      |  |     |      |  |  |
| IMMEDIATE CAUSE (a) Possible Aspiration Pneumonia   |  |  |  |        |      |  |     |      |  |  |
| 3451 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |        |      |  |     |      |  |  |
| Convulsive disorder, symptomatic Epilepsy   |  |  |  |        |      |  |     |      |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |        |      |  |     |      |  |  |
| 3533 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |        |      |  |     |      |  |  |
| (c)   |  |  |  |        |      |  |     |      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |        |      |  |     |      |  |  |
| Cortical atrophy due to anoxia at birth   |  |  |  |        |      |  |     |      |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |      | 20a. AUTOPSY?  |     |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |        |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |     |      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY  |        |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |     |      |  |  |
|   |  |  | HOUR A.M. Month Day Year P.M. 19   |        |      |  |     |      |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        |      | 21f. LOCATION  |     |      |  |  |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |        |      | Street or R.F.D. No. City or Town County State   |     |      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/21, 1962, to 7/11, 1968, that (X) (we) last saw the deceased alive on 7/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |        |      |  |     |      |  |  |
| 22b. SIGNATURE  |  |  |  |        |      | DEGREE   |     |      | 22c. DATE SIGNED   |  |
| Harry G. Butler   |  |  |  |        |      | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |     |      | 11 July 68   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |        |      | 22e. ADDRESS   |     |      |  |  |
| Harry G. Butler M.D.  |  |  |  |        |      | Rosewood State Hospital  |     |      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |        |      | 23c. NAME OF CEMETERY OR CREMATORY   |     |      | 23d. LOCATION (City or Town) (County) (State)                        |  |
| Burial  |  |  | 7/13/68.   |        |      | Baltimore Memorial Pk.   |     |      | Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS  |        |      | 25a. REC'D BY REGISTRAR  |     |      | 25b. REGISTRAR'S SIGNATURE   |  |
| Leonard J. Rock   |  |  | 535 N. Harbor Rd.  |        |      | JUL 12 1968  |     |      | Charles Judge  |  |

00000

STATEMENT OF DEBIT

00000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| Item#23c,d,FilmG403 8/5/68 km   |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>NETTIE GERTRUDE MILLER   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>7 25 68  |  | 2b. HOUR<br>5:05 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>6/30/1896   |  | 6. AGE (In years last birthday)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>RIDERWOOD  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>1629 W. JOPPA ROAD                     |  |
| 14. FATHER'S NAME First Middle Last<br>GEORGE E. BISHOP   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>MOLLIE CHENOWITH  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>NONE   |  | 17. INFORMANT Address<br>FAMILY RECORDS   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Extensive myocardial infarcts</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u><br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                 |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Diabetes mellitus with renal papillary necrosis   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>68</u> , to <u>7/25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Rudiger Breitenecker</i>   |  | DEGREE<br>M.D.   |  | ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED<br>7/26/68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Rudiger Breitenecker, M.D.  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>7/29/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Saters Baptist Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Lutherville, Balto. Co., Md.                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>John Burns &amp; Sons</i>  |  | ADDRESS<br>610-12 York   |  | 25a. REC'D BY REGISTRAR<br>JUL 31 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |

023200

HEAD 16

203.0

023200

023200

## CERTIFICATE OF DEATH

09646

09657

|   |  |   |       |  |   |   |  |                           |                  |  |
|---|--|---|-------|--|---|---|--|---------------------------|------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First | Middle   | Last  | 2a. DATE OF DEATH   |  |                           | 2b. HOUR         |  |
| BABY  |  |   | BOY   | MOORE  | JULY Month 30, Day 1968 Year  |   |  | 4:30 M                    |                  |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR           |                  | IF UNDER 24 HRS.   |
| MALE  |  | WHITE   |       | JULY 30, 1968  |   | YRS.  |  | MONTHS                    | DAYS             | HOURS MIN.   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  | 10. CITY OR TOWN OF DEATH |                  |  |
| MARYLAND  |  | U.S.A.  |       |  |   | BALTIMORE,  |  | TOWSON                    |                  |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |       | 12b. KIND OF BUSINESS OR INDUSTRY  |   | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |  | 13b. CITY OR TOWN         |                  | 13c. INSIDE CITY LIMITS?                                 |
| ST. JOSEPH HOSPITAL   |  |   |       |  |   | MARYLAND  |  | BALTIMORE                 |                  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT             |                  | Address  |
| JOSEPH G. MOORE   |  | BARBARA J. LAMB   |       |  |   |   |  |                           |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |       |  |   |   |  |                           |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 1. DEATH WAS CAUSED BY:  |  |   |       |  |   |   |  |                           |                  |  |
| IMMEDIATE CAUSE (a) 777X  |  |   |       |  |   |   |  |                           |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |       |  |   |   |  |                           |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |       |  |   |   |  |                           |                  |  |
| (b) Immaturity  |  |   |       |  |   |   |  |                           |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |       |  |   |   |  |                           |                  |  |
| (c)   |  |   |       |  |   |   |  |                           |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |       |  |   |   |  |                           |                  |  |
| 776X  |  |   |       |  |   |   |  |                           |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                           |                  |  |
|   |  |   |       |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |                           |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY   |       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                           |                  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19  |       |  |   |   |  |                           |                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)            |       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |                           |                  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |   |       |  |   |   |  |                           |                  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from July 30, 1968, to July 30, 1968, that (X) (we) last saw the deceased alive on July 30, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |   |       |  |   |   |  |                           |                  |  |
| 22b. SIGNATURE  |  |   |       |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                           | 22c. DATE SIGNED |  |
| Nathan Block MD   |  |   |       |  |   |   |  |                           | July 31, 1968    |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |       |  | 22e. ADDRESS  |   |  |                           |                  |  |
| Nathan Block, M.D.  |  |   |       |  | Ridge Rd., Baltimore, Md. 21206   |   |  |                           |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |                           |                  |  |
|   |  | 8-7-68  |       | V. of Md. Quad. 3d. V. of Md. Quad.  |   | Baltimore, Md.  |  |                           |                  |  |
| 24. FUNERAL DIRECTOR  |  |   |       |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                           |                  |  |
|   |  |   |       |  | DATE  |   | AUG 9 1968   |                           |                  |  |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

81-17498

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

12380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |                                    |   |   |   |  |  |
|--|--|--|--|------------------------------------|---|---|---|--|--|
| CERTIFICATE OF DEATH   |  |  |  |                                    |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |                                    |   | 2a. DATE OF DEATH   |   |  | 2b. HOUR   |
| EVELYN   |  |  | LIL  |                                    |   | MOORE   |   |  | P  |
| 3. SEX   |  |  | 4. RACE  |                                    |   | 5. DATE OF BIRTH  |   |  | 6. AGE (In years lost birthday)  |
| FEMALE   |  |  | CAUCASIAN  |                                    |   | 6/21/98   |   |  | 70 YRS.  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH   |
| MD.  |  |  | USA  |                                    |   |   |   |  | BALTIMORE Md.  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| BALTIMORE  |  |  | GREAT. BALT. MED. CEN.   |                                    |   | Operator-Hswi.  |   |  | Telephone  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |                                    |   | 13c. CITY OR TOWN   |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Md.  |  |  | BALTO.   |                                    |   | BALTO.  |   |  | 13e. STREET AND NUMBER   |
|  |  |  |  |                                    |   |   |   |  | 337 Overbrook Rd.  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |                                    |   |   |   |  |  |
| First Middle Last  |  |  | First Middle Last  |                                    |   |   |   |  |  |
| James W. Warrington  |  |  | Florence Melvin  |                                    |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |                                    |   | 17. INFORMANT Address   |   |  |  |
| No   |  |  | 214-22-3325  |                                    |   | James W. Moore Same-Above   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |                                    |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |                                    |   |   |   |  |  |
| IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>  |  |  |  |                                    |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |                                    |   |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |                                    |   |   |   |  |  |
| (b) <b>CONJESTIVE HEART FAILURE</b>  |  |  |  |                                    |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |                                    |   |   |   |  |  |
| (c) <b>HYPERTENSION</b>  |  |  |  |                                    |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |                                    |   |   |   |  |  |
| 443X   |  |  |  |                                    |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |
|  |  |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |   |   |  |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |                                    |   |   |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |  |  |
|  |  |  |  |                                    |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23, 19 68, to 7/23, 19 68, that (I) (we) last saw the deceased alive on 7/23, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                    |   |   |   |  |  |
| 22b. SIGNATURE   |  |  |  |                                    | DEGREE  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |
| A. PIRNIA, M.D.  |  |  |  |                                    |   |   |   |  | 7/23/68  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |                                    | 22e. ADDRESS  |   |   |  |  |
| A. PIRNIA, M.D.  |  |  |  |                                    | 6701 NORTH CHARLES BALT., MD.   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)   |   |  |  |
| Burial   |  | 7-27-68  |  | Dulaney Valley Mem.                |   | Timonium Balto., Md.  |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |  |
| H.W.Jenkins & Sons Co. 4905 York Rd., Balto.   |  |  |  |                                    | JUL 25 1968   |   | Charles Judge   |  |  |

100000

100000

00:00 1000 1000 1000

1000 1000 1000 1000

1000 1000

1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000

1000 1000

1000 1000 1000 1000

1000 1000

1000 1000 1000 1000

1000 1000

1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000



CERTIFICATE OF DEATH

09648

09659

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Towson</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>215 W. Chesapeake Ave.</b>   |   | d. STREET ADDRESS<br><b>215 W. Chesapeake Ave.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Gertrude Norman Morningstar</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>13</b> Year <b>1968</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 19, 1882</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 9. AGE (In years last birthday) yrs.<br><b>85</b>                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Milford Scott Flowers</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Katye Price</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Family Records</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO (b) <b>Hypertension</b><br>DUE TO (c) <b>Aortic Aneurysm</b>                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-yr</b><br><b>1-yr</b>                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>331X</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (his hospital) attended the deceased from <b>July 1, 1956</b> to <b>July 13, 1968</b> that (I) (we) last saw the deceased alive on <b>June 27, 1968</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above. |   |   |  |
| 22a. SIGNATURE<br><b>George T. Gilman</b>   |   | 22b. DATE SIGNED<br><b>July 17, 1968</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State)  |
| <b>Burial</b>   | <b>July 16, 1968</b>  | <b>Prospect Hill Cem.</b>   | <b>Towson, Md.</b>   |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 18 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10055

RECEIVED

10055



10055 JUL 1 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09649

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09660

|   |  |  |   |   |  |  |  |  |   |  |
|---|--|--|---|---|--|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CATHERINE S. MORROW</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1968</b>                                  |   |  | 2b. HOUR<br><b>2 a</b> M   |  |  |   |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>caucasian</b>                |   | 5. DATE OF BIRTH<br><b>March 26, 1882</b>   |  | 6. AGE (In years last birthday)<br><b>86</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>101 Burke Ave.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b>                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET AND NUMBER<br><b>5006 Remmell Ave.</b>  |  |  | 14. FATHER'S NAME<br>First <b>Conrad</b> Middle <b>Kahler</b> Last <b>Unknown</b>                     |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>   |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>Unk.</b>   |   |  | 17. INFORMANT<br>Address <b>Mrs. Harry B. Freeburger, 101 Burke Ave.</b>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>4200</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                     |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUN 1966</b> to <b>JUL 2, 1968</b> , that (I) (we) lost the deceased alive on <b>JUL 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>T. C. Siwinski</b>   |  |  |   |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>July 2, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. Thaddeus C. Siwinski</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>206 W. Pennsylvania Ave, Towson</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  |  | 23b. DATE<br><b>7/5/68.</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Leonard J. Ruck, Inc, -Balto, Md. -14</b>   |  |  |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL - 2 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

100000

000000

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

ADJUTANT GENERAL

USA

100000000

100000000

100000000

100000000

100000000

100000000

100000000



100000000

100000000

100000000

100000000

100000000

100000000

100000000

100000000

100000000

100000000

12  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09650   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201          |  |  |  |  |  |  |  |  |  | 09661   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| JACOB G. MOSES  |  |  |  |  |  |  |  |  |  | 7 Month 02 Day 68 Year   |  |  |  |  |  |  |  |  |  | 1:16 AM   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>MALE  |  |  |  |  |  |  |  |  |  | 4. RACE<br>CAUCASIAN   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>11-03-1882  |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)<br>85 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN    |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTIMORE, MARYLAND  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>BALTIMORE COUNTY Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>GBMC |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>PROPRIETOR ADVERTISING BUSINESS                                  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>BALTIMORE   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>1010 ST. PAUL ST. |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>MYER   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>ROSE LAZANSKY  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>219-32-0902  |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>MISS FANNIE F. MOSES, address 1010 ST. PAUL ST.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4210 SUBACUTE BACTERIAL ENDOCARDITIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4300 CONGESTIVE HEART FAILURE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1968                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)         |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-29, 1968, to 7-02, 1968, that (I) (we) last saw the deceased alive on 7-02, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>DR. GEORGE PIKLER   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>7-02-68  |  |  |  |  |  |  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>DR. GEORGE PIKLER   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>GREATER BALTO. MEDICAL CENTER   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>7-4-68  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>JUL - 8 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |

13330

01700

13330

01700

01700

01700

13330

01700

01700

13330

01700

01700

13330

01700

01700

13330

13330

13330

01700

01700

01700

13330

13330

01700

13330

01700

01700

13330

01700



M-1

09651

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09662

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>LAURA B. MOSSBURG                           |   |   | 2a. DATE OF DEATH<br>Month Day Year<br>July 17 1968   |   | 2b. HOUR<br>11:45 AM   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>11-10-'82   |   | 6. AGE (In years last birthday)<br>85 YRS.                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br>Balto, Md   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore Co. Md.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catoxville  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Shady Nook N.H.H. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md. | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br>2516 Poplar DR                        |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Edward B. Bordley  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Emma M. Cooper                                   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No                            | (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.<br>213-65-8855   | 17. INFORMANT<br>Address<br>Mr. P.L. Mossberg, Drexel Hill, Pa. |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4129

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4221

MEDICAL CERTIFICATION

|  |   |  |  |              |
|--|---|--|--|--------------|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  | 21f. LOCATION<br>Street or R.F.D. No.  | City or Town   | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-17-1965, to 2-17-1968, that (I) (we) lost saw the deceased alive on 7-17-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |              |
| 22b. SIGNATURE<br>Harry L. Knipp, MD   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br>7-18-68  |  |              |
| 22d. PHYSICIAN'S NAME (Type)<br>HARRY L. KNIPP, MD   | 22e. ADDRESS<br>416 Edmondson Ave. Baltimore, Md.   |  |  |              |

|  |                      |   |   |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial      | 23b. DATE<br>7/20/68 | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PK. Cem. | 23d. LOCATION (City or Town) (County) (State)<br>Balto. Md. |
| 24. FUNERAL DIRECTOR<br>Wm. J. Tichauer & Son Balto. Md. |                      | 25a. REC'D BY REGISTRAR<br>DATE JUL 22 1968             | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13330

13330

*Handwritten signature*

13330

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                  |  |  |   |  |   |  |   |  |
|--|------------------|--|--|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |                  | First<br>Rose  |  | Middle<br>E.  |  | Last<br>Mozingo   |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> July 22 19 68 |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>March 15, 1917   |  | 6. AGE (In years<br>last birthday)<br>51 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Illinois   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>July 22 19 68   |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>7823 Fairgreen Road |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>Retired Clerk Balto.   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>News Post   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission), STATE<br>Maryland  |                  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>7823 Fairgreen Rd.  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Byron M. Matthai Sr.   |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Lenise Harbor   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213-18-7868                |  | 17. INFORMANT (Daughter<br>ADDRESS Dundalk, Md.<br>Mrs. Cherie Kamminga, 7823 Fairgreen Rd.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>ACVD</u> DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201   |                  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <u>Theodore C. Patterson</u> M.D.<br>EXAMINER'S NAME (Type) Theodore C. Patterson M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> 3724 Dundalk Ave.<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED <u>7/23/68</u><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) Dundalk, Md. 21222 |                  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Cremation   |                  | 23b. DATE<br>7/26/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.  |                  |  |  | 25a. REC'D BY REGISTRAR<br>DATE JUL 25 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judson</u>   |  |   |  |

00000

00000

RECEIVED EXHIBIT - CIVIL RATE OF DEATH

FOR STATE

RECEIVED

(M)

(1)

|                          |  |                          |  |                          |  |                          |  |
|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|
| Date of Birth            |  | Date of Death            |  | Place of Birth           |  | Place of Death           |  |
| July 22, 1900            |  | July 22, 1900            |  | New York City            |  | New York City            |  |
| Age                      |  | Age                      |  | Sex                      |  | Race                     |  |
| 20                       |  | 20                       |  | Male                     |  | White                    |  |
| Marital Status           |  | Marital Status           |  | Occupation               |  | Cause of Death           |  |
| Single                   |  | Single                   |  | Student                  |  | Diphtheria               |  |
| Education                |  | Education                |  | Religion                 |  | Burial Place             |  |
| High School              |  | High School              |  | Catholic                 |  | Catholic Cemetery        |  |
| Previous Illnesses       |  | Previous Illnesses       |  | Family History           |  | Medical History          |  |
| None                     |  | None                     |  | None                     |  | None                     |  |
| Exposure to Infection    |  | Exposure to Infection    |  | Treatment                |  | Prognosis                |  |
| Yes                      |  | Yes                      |  | None                     |  | Poor                     |  |
| Contact with Sick Person |  | Contact with Sick Person |  | Contact with Sick Person |  | Contact with Sick Person |  |
| Yes                      |  | Yes                      |  | Yes                      |  | Yes                      |  |
| Name of Doctor           |  | Name of Doctor           |  | Name of Doctor           |  | Name of Doctor           |  |
| Dr. J. H. Smith          |  | Dr. J. H. Smith          |  | Dr. J. H. Smith          |  | Dr. J. H. Smith          |  |
| Signature of Doctor      |  | Signature of Doctor      |  | Signature of Doctor      |  | Signature of Doctor      |  |
| [Signature]              |  | [Signature]              |  | [Signature]              |  | [Signature]              |  |
| Date of Report           |  | Date of Report           |  | Date of Report           |  | Date of Report           |  |
| July 25, 1900            |  | July 25, 1900            |  | July 25, 1900            |  | July 25, 1900            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |  |                           |  |  |
|---|--|---|--|---|---|--|---------------------------|--|--|
| <div>09653</div> <div>CERTIFICATE OF DEATH</div> <div>09664</div>   |  |   |  |   |   |  |                           |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>FRANK</b>  |  |   |  |   | 2a. DATE OF DEATH<br>Month <b>JULY</b> Day <b>12</b> Year <b>1968</b> |  | 2b. HOUR<br><b>7:25AM</b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>6/5/05</b>   |   | 6. AGE (In years last birthday)<br><b>63</b> YRS.  |                           | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.   |                           |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETAIL CLERK</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD FAIR STORE</b>                                  |                           |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 13e. STREET AND NUMBER<br><b>6808 Roberts Avenue</b> |  |
| 14. FATHER'S NAME First <b>Walter</b> Middle <b>Mulkytin</b> Last _____   |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Kazmiera</b> Middle <b>Roszanski</b> Last _____   |   |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>210 01 50 99</b>   |  | 17. INFORMANT Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |   |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, UNDETERMINED ORGANISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UNDIAGNOSED RIGHT LUNG TUMOR</b> |  |   |  |   |   |  |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |                           |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <b>NO AUTOPSY</b>        |                           |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____ 19 _____            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                           |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |   |  |                           |  |  |
| 22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>5/1/68</b> , 19____, to <b>7/12/68</b> , 19____, that (if) (we) lost saw the deceased alive on <b>7/12/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.   |  |   |  |   |   |  |                           |  |  |
| 22b. SIGNATURE<br><b>Neilon Neilson M.D.</b>  |  |   |  | DEGREE _____ ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                |   | 22c. DATE SIGNED<br><b>7/12/68</b>   |                           |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>NEILON NEILSON, M. D.</b>  |  |   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>7-15-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART OF MARY</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>GERMAN HILL ROAD, DUNDALK, MD.</b>       |                           |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  | ADDRESS<br><b>WALTER DABROWSKI FUNERAL HOME</b>   |   | 25a. REC'D BY REGISTRAR<br><b>5 1968</b>   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |



1966

DEPARTMENT OF HEALTH

1966

STATE ALABAMA COUNTY

DATE JULY 12 1966

TIME 10:00 AM

PLACE OF BIRTH

AGE 30

SEX MALE

EDUCATION

RELIGION

REASON FOR VISIT

DATE OF VISIT

NAME OF PHYSICIAN

ADDRESS

CITY

STATE

ZIP CODE

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

AGE



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09654

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09665

|  |                         |   |  |   |  |   |                                     |   |  |
|--|-------------------------|---|--|---|--|---|-------------------------------------|---|--|
| 1. DECEASED NAME<br>(Type or Print)<br><b>Jacqueline E. Murray</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month <b>7</b> Day <b>29</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>5:45 P.M.</b>  |                                     |   |  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br><b>SEPT. 25, 1943</b>   | 6. AGE (In years last birthday)<br><b>25 YRS.</b>  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b> DAYS<br><b>0</b>  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b>   | 2c. DATE PRONOUNCED DEAD<br>Month <b>July</b> Day <b>29</b> Year <b>1968</b>                    |                                     |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |                                     |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1612 Apt. G., Rickenbacker Rd.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SEAMSTRESS</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     | 13e. STREET AND NUMBER<br><b>400 Longley Road</b>                                   |  |
| 14. FATHER'S NAME<br>First <b>JOHN E.</b> Middle <b>HOFFMAN</b> Last <b>HOFFMAN</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First <b>GERTRUDE</b> Middle <b>DELLINGER</b> Last <b>DELLINGER</b>              |   |  |   |                                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(If give war or dates of service)   |  | 17. INFORMANT<br><b>GERTRUDE HOFFMAN</b>  |  |   | ADDRESS<br><b>400 EDGEWOOD APTS</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound of Chest</b><br><b>955X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>976X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |   |  |   |  |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>976X</b>  |                         |   |  |   |  |   |                                     |   |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>4:30 P.M. 7/29 19 68</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>subj. shot self in chest</b>  |  |   |                                     |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>boyfriend's apartment</b>          |  | 21f. LOCATION Street or R.F.D. No.<br><b>Essex,</b>   |  | City or Town<br><b>Baltimore,</b>   |                                     | County<br><b>Md.</b>  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |  |   |  |   |                                     |   |  |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>   |                         | EXAMINER'S NAME (Type)  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |                                     | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                    |  |
|  |                         |   |  | ADDRESS (Street, city, town, or county)   |  | 22b. DATE SIGNED<br><b>7/30/68</b>  |                                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>8/2/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEM</b>   |  | 23d. LOCATION (City or Town)<br><b>BALTO. MD</b>  |                                     | (County) (State)  |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>  |                         |   |  | ADDRESS<br><b>300 MACE</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 2 1968</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                               |  |

03000

03000

42

03000

03000 03000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |
|---|--|--|--|
| 09655   |  |  |  |
| 09666   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | 2a. DATE OF DEATH  |  |
| First Middle Last<br><b>Louis E. Myers</b>  |  | Month Day Year<br><b>July 26, 1968</b>   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Negro</b>  |  |
| 5. DATE OF BIRTH<br><b>Sept. 22, 1935</b>   |  | 6. AGE (In years last birthday)<br><b>32</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b>  |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>vendor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>produce</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  |
| 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  |
| 13e. STREET AND NUMBER<br><b>1923 W. Baltimore</b>  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Walter Myers</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Bernice Loyles</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-8959</b>   |  |
| 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Left leg thrombophlebitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>463X Ascites of unknown cause</b>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 29, 1968</b> , to <b>July 26, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |
| 22b. SIGNATURE<br><b>Diomidis Pirovolidis</b>   |  | 22c. DATE SIGNED<br><b>7-26-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Diomidis Pirovolidis, M.D.</b>   |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>7/31/1968</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wm. L. DuFurn Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Williams Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 31 1968</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

03368

03368

03368



03368 18 JUL 1950